THE CANADIAN HOSPITAL

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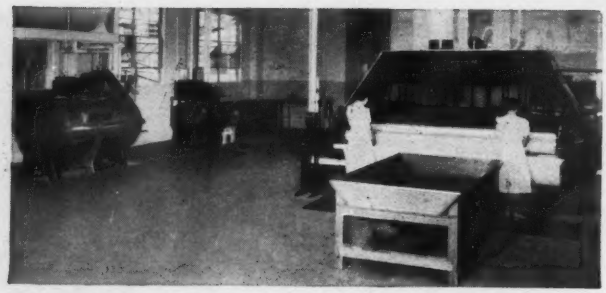
CANADIAN HOSPITAL COUNCIL

SILVER JUBILEE NUMBER
FEBRUARY, 1949

"Know how"

Modernized the Laundry Dept. at 75-Bed Orthopaedic Hospital, Los Angeles



In bright, spacious laundry department, are two NORWOOD CASCADE Washers, left. 4-Roll STREAMLINE Ironer, right, irons all linens.

American Extractor, right, removes water from washed work. Pieces not to be ironed, go to ZONE-AIR Drying Tumblers, left.

All uniforms and staff's personal apparel are neatly ironed on this SUPER-ZARMO, SUPER-ZARMOETTE Press Unit.

Problem

To insure efficient operation of expanded facilities from the start, Orthopaedic Hospital decided to modernize the laundry department first. Question: What size and type equipment to install?

Solution

Hospital called in our Laundry Advisor. He carefully analyzed present and anticipated requirements. Based on his findings and experience, he submitted recommendations and a suggested laundry layout. Latest, cost-reducing machines were installed in a new building.

Results

Plentiful flow of sterile-clean linens meets all requirements of increased hospital facilities. Laundering quality is outstanding. Equipment requires less operator effort; working conditions are improved.

***Large* or *small* hospitals may obtain the service of our Laundry Advisor, without cost or obligation. WRITE TODAY.**

Remember *Every Department of the Hospital Depends on the Laundry*

Your hospital will benefit by selecting from Canadian's complete line of most advanced and productive hospital laundry equipment.

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Time Saved

Every Baxter expendable administration set that is used means cleaning time saved, sterilization time saved and assembling time saved, because Baxter expendable sets are ready to use—clean, sterile, non-pyrogenic. There are Baxter expendable sets for solution administration, for blood collection and blood and plasma administration. An adequate stock of expendable sets plus Baxter solutions insures that the hospital is ready for any emergency. A request on your hospital stationery will schedule a demonstration of all Baxter expendable sets.

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Contents

Vol. 26 **FEBRUARY, 1949** No. 2

As Sterile Pack Sutures are received at the hospital. Six dozen tubes in antiseptic storage fluid, packed in a sturdy, sealed metal canister.

Canister is easily and quickly opened with key whenever additional sutures are needed. Labels clearly indicate type and size in canister.

Ready to use without scrubbing. Six dozen sterile tubes in tubing fluid. Tubes do not float in solution. When empty, canister is discarded.

Chrome metal covers, supplied by Ethicon, protect contents of canister in use. The covers last indefinitely and are easily sterilized.

Here's How You Save with Sterile Pack

• Your hospital is facing serious labor and nursing personnel problems and rising costs.

Most hospital administrators today realize that they must compete with industry for their labor and other personnel; that they can no longer afford to hire people to perform functions within the hospital that can be done better and cheaper outside.

Ethicon Sterile Pack Sutures release skilled operating room personnel for other more constructive operating room functions.

See How Much You Can Save

Most hospitals require an average of four "nurse hours" per week per hundred beds to prepare standard tube sutures and suture jars. At even $1.00 per hour, this is $4.00 per week or $208.00 per year for labor now eliminated by Sterile Pack!

Current surveys show that Sterile Pack sutures will save most hospitals a sum equal to from 15% to 20% of the cost of their standard tube sutures. Including costs of fluid, suture jars, lids and time, your hospital may effect savings equal to from $3 to $4 on every canister of Sterile Pack sutures purchased.

Then, consider your tube breakage, which averages 3% in most hospitals. Your savings from reduced breakage in a 100-bed institution will run as high as $50.00 a year.

The types and sizes of Ethicon Sterile Pack Sutures represent about 80% of all sterile sutures used in most operating rooms.

Ethicon Non-Boilable Surgical Gut is supplied in Sterile Pack canisters in Standard Tubes only, at present. Type A, Plain, and Type C, Medium Chromic, are supplied in sizes 000, 00, 0, 1, and 2. One canister contains 6 dozen standard tubes of one type and size.

In each canister all tubes are covered with a colored antiseptic storage fluid capable of sterilizing and maintaining sterility before as well as after the canister seal is broken. Storage fluid from empty canisters may be safely used in partly empty canisters to keep the fluid at the proper level.

The ingredients of Sterile Pack storage fluid: Isopropyl alcohol, 70%; formaldehyde, 1%; sodium nitrate, 1/10%; sodium bicarbonate, 1/10%; water, q.s. ad 100%.

Call in your Ethicon representative. He will get you started on the Sterile Pack program in your hospital.

ETHICON SUTURES IN STANDARD TUBES ARE NOW SUPPLIED IN TWO WAYS

I. Regular Pack.....1 Dozen tubes in cardboard box

II. Sterile Pack.....6 Dozen tubes in metal canister

ETHICON Sutures — Johnson & Johnson LIMITED MONTREAL

Across the Desk

By C.A.E.

Canadian International Trade Fair

The Canadian International Trade Fair will be held in the Canadian National Exhibition grounds in Toronto from May 30 to June 10, 1949. Business men from over 70 countries visited the 1948 Fair, and more than 1,400 exhibits displayed the products of 28 different nations. The Trade Fair site contains the largest permanent exhibition buildings in the world. The area of the Fair is a Free Port, enabling exhibitors to store adequate quantities of sample goods on the premises in bond. Many special personal services, including guides, interpreters, and stenographic facilities, will be available to visitors from abroad.

* * * *

McKague Chemical Co. Make Changes

The McKague Chemical Company held their annual sales meeting at the Royal York Hotel, Toronto, on December 28, 29 and 30th. The year 1948 was the most successful in the Company's history and plans were discussed for further expansions in 1949. The keynote of the meeting was Service, and methods were planned to further the Company's service to their clients.

Some changes in the sales organization were announced by Mr. W. Green, Sales Manager, to take effect the first of the year. Mr. Harold Moore, who formerly covered the Laundry and Dry Cleaning trade in Toronto and all classes of Industry in Eastern Ontario, west of Kingston, has been promoted to be Supervisor of the Laundry and Dry Cleaning Division. Mr. Keith Ferris, a graduate of Ontario Agriculture College, who has been working the Hotel and Restaurant trade in Toronto for the Company for the last two years will now cover the Hospital and Institutional fields in Toronto and all classes of trade in Eastern Ontario, west of Kingston. Mr. Charlie Armstrong, a new member of the organization is servicing the Hotel and Restaurant trade in Toronto. The remainder of the Sales Staff, Wally Johnston, Howard McKague, Alex Milne and Pete Petry, will continue as before.

* * * *

Change in Ownership of Physicians' Record Company

The Physicians' Record Company, Chicago, which was founded in 1907, announce that F. M. Kraman and J. W. Voller, who have been with the business since 1920, have

(Continued on page 16)

Are you Trapped

. . . By High Costs and Low Food Budgets?

Most of the nation's hospitals are operating at a deficit in their food departments. What to do when you want to stretch every food dollar farther and still not lower your quality standards?

Gumpert has the answer — a practical answer, born of more than half a century of creating finer foods for large-scale feeding. Gumpert has perfected literally hundreds of food specialties that afford home-style flavor and goodness at per portion costs economical enough to fit the needs of budget buyers.

Gumpert food products give you important savings in time and effort. They give you uniformity which assures results with each preparation, regardless of the number of servings. They put delicious flavor on the table in timely new popular dishes. In Gumpert specialties, most of the important ingredients are in already. Your job of preparation is simple.

Ask your Gumpert Man. He can help to make your food budget click and buy more goodness for your dollar.

S. GUMPERT CO. OF CANADA, LTD.

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200 Profit-Building Products to Aid Restaurants and Institutions

Gelatine Desserts
Cream Desserts
Pie and Cake Fillings
Extracts and Colors
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Cake Bases
Numerous Other Cooking Aids
Complete Line of Bakery

FOR THE FINEST IN FOODS

GUMPERT

has EVERYTHING

Across the Desk

(Continued from page 12)

acquired ownership of the company. F. M. Kraman has been elected President and J. W. Voller has been elected Secretary-Treasurer. The general policy of the company will continue without interruption.

* * * *

Stevens Companies New Catalogue

Profusely illustrated and containing detailed descriptions of hundreds of items of hospital apparatus, equipment and supplies, the new 280-page catalogue just issued by The Stevens Companies will prove an invaluable aid to the hospital buyer.

New equipment, new techniques and procedures have been dealt with exhaustively, and the Stevens Companies are to be congratulated on the production of a very complete presentation of material of interest to the hospital worker, both lay and professional.

A copy may be obtained by writing to any one of the Stevens offices.

* * * *

New Class 200 National Cash Register

The Class 200 Natonal Cash Register is a compact, moderately priced cash register with capacity from one cent to $999.99 and designed to provide a complete system for many types of users.

Features of the Class 200 National not found in any other type of cash register are (1) a column selector device through which sales information is distributed and printed in appropriate columns on an eight - column audit tape, and (2) the additional service of a listing or adding unit. This adding unit is available at all times to help the user list cheques, make up cash deposits, prove patients' or customers' accounts when receiving payments, prove invoices when paying for goods by cash, or do any other work requiring listing or adding without affecting the locked-in register total of the day's business.

The columnar audit tape gives the user a record of his sales by departments, or such other classifications as he may wish, and enables him to get a breakdown of expenses, distribution of taxes, or other statistical information. Through a small window at the right of the visible audit tape, the user can make penciled notations concerning any transaction.

The new Class 200 Nationals are now built in Canada and are on hand for demonstration at any of the Company's branch offices in the Dominion. Orders are being accepted for early delivery.

* * * *

New Heidbrink Catalogue of Anaesthesia Apparatus

More than 50 models of inhalation anaesthesia machines are described in a 32-page catalogue of Heidbrink Surgi-

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Across the Desk

(Concluded from page 16)

cal Anaesthesia Apparatus issued by Ohio Chemical Canada Limited, Toronto.

Included are 4-gas Kinet-o-meters of the cart type, using large cylinders of gas, 4-gas wheeled stand models using small cylinders, cabinet type Kinet-o-meters for large and small cylinders, and a Junior portable outfit weighing only 35 pounds. The Junior machine is available with or without an obstetrical automat, as specified.

In addition to attachments for the administration of cyclopropane, available for most of the machines, the Heidbrink line includes Kinet-o-meters designed especially for the administration of cyclopropane and three other gases—nitrous exide, ethylene and carbon dioxide.

* * * *

Gordon MacEachern Appointment

It has been announced that Edward Fullerton has been appointed Director of Services for the firm of Gordon A. MacEachern, Building Maintenance and Floor Finishing Specialists, Toronto.

A past president of the Toronto Building Superintendents Association, a stationary engineer, formerly Superintendent of Buildings of the Toronto Transportation Commission, Maintenance Engineer of the Toronto Public Libraries, Mr. Fullerton is well-known in the building trades.

* * * *

Canadian Nickel Strategic Metal

Canadian nickel is now one of the most strategic metals in the world, C. E. Macdonald, International Nickel's manager of Canadian sales stated recently before a meeting of nickel distributors from all parts of the Dominion at Montreal. He pointed out that recent surveys showed that nickel or its alloys are now being used in more than 75 different industrial fields where its toughness and anti-corrosion qualities make it a vital component of machinery or equipment. Hospitals, of course, are large users of Monel metal in kitchens, laundries, operating rooms, et cetera.

Throughout the world, industry is constantly discovering new uses for this Canadian metal, he continued—from alloys containing less than one percent to malleable nickel in its pure form.

More than two-thirds of Canada's nickel output is sold for U.S. dollars. An additional 27% is sold in England and elsewhere for sterling, he said, pointing out the importance of the industry in maintaining the Dominion's foreign exchange position.

* * * *

Modern Parents

Mother (on telephone): Helen, dear, could father and I leave your children with you and Bob this evening? We're invited out to a bridge party.

THE CANADIAN HOSPITAL

Toronto, February, 1949 Vol. 26 No. 2

Looking Back a Quarter Century

Harvey Agnew, M.D.

TWENTY-FIVE years ago this month the first issue of this journal was published for the approval of the hospital field; reference to that issue appears elsewhere in this number.

Although twenty-five years is a short space when weighed against long centuries of hospital evolution, this particular quarter century has been an unusually important one in hospital history. While technique in general and surgical technique in particular probably made more sweeping advances in the previous quarter century, it would seem logical to assert that this past twenty-five year period has witnessed the greatest advances in the social and economic applications of these scientific developments.

To select a specific example, much ground work had been done before 1924 in the development of blood transfusions. The late Bruce Robertson was probably the first man to do successful blood transfusions on the battlefield, an achievement of World War I. Various pieces of equipment for direct blood transfusion were developed during and following the first War. But only since 1924 have transfusions become other than a major event in many hospitals. Now we no longer debate whether to follow the Jansky or the Moss four-group designations (the writer was a Jansky man); in fact we have discarded both. Since then dried blood and blood derivatives have revolutionized the use of this vital therapy. The tremendous contribution of the Red Cross Society, first during World War II and now with its civilian blood donor program, saved the lives of thousands during the War and may well do a similar service to the civilian population.

Similarly, blood chemistry was making great strides in the late 'teens and early twenties, but few hospitals apart from the larger teaching ones did more than the elementary tests; competent technicians were scarce and most staff doctors were still hazy about the clinical application of many of the estimations, such as for blood chlorides, blood N.P.N., chloresterol, et cetera. Basal metabolism tests, when done prior to 1924, were still done by the physician in most instances and electrocardiography was just coming into general use. Electroencephalography had not yet been developed.

Social Legislation

Much of our social legislation has developed so gradually that it is not easy to visualize the time when many features of today were non-existent. Twenty-five years ago only a few provinces had workmen's compensation, and many doctors and employers were dubious of the value of that innovation. Medical relief, as we now know it, was non-existent. There was no unemployment insurance, no old age pensions, mothers' allowances, or children's allowances. Provincial grants and municipal payments were much less adequate than they are today. It is our recollection that there were no payments for new-born babies or to hospitals for the chronically ill or the convalescent as in several provinces today. No special grants were available for construction or for cancer centres. Quebec did not have its meal tax to help hospitals. Insulin was be-

ing distributed free by one province only. Little free laboratory service was being given by the provincial governments.

At that time there were no Blue Cross plans to aid hospital finance, although a number of communities had local "check-off" or other contributory schemes. The Alberta free maternity care was not to come for many years and, of course, the still more recent compulsory hospitalization plans of Saskatchewan and British Columbia had not been drafted. There were no hospital unions to bring more headaches to the administrator.

The hospital acts in some of the provinces were then (and for some time afterward) very sketchy and the "regulations appertaining thereto" were even more so. Many points were not covered or were not dealt with adequately. Most of these have since been clarified. In 1924 no province protected the hospital or doctor by lien laws or other measures in the case of traffic accidents. Hospitals were still subject to the statutory six-year "limitation of liability" period, whereas now it is considerably shortened in most provinces. Federal control of the misbranding of drugs was not effective until 1927. Hospitals were subject to the sales tax from 1920 on. By 1924 this had risen to 6 per cent. The tax then dropped to lower levels but by 1932 was again up to 6 per cent and headed for the apparenly permanent 8 per cent. At this point the recently formed Canadian Hospital Council was able to obtain exemption of public hospitals from this tax.

Although the standardization program of the American College of Surgeons (under the guidance of the late Dr. Franklin Martin and the immediate direction of our own Dr. Malcolm T. MacEachern, ably supported by the late Father Moulinier) had been under way for some years, several of our better known hospitals had not been approved in 1924 and their medical staffs were still quite critical of the movement. This has long since been corrected. At this time the College had 77 Canadian hospitals on its list of approved hospitals; 19 more were partially approved, making a total of 96. Now there are 207 approved and 39 conditionally approved Canadian hospitals, making a total of 246.

In 1924 there was no approval of hospitals for internship, no approval of residencies in specialties by the Royal College of Physicians and Surgeons of Canada, nor by the American College of Surgeons; in fact the Royal College in Canada had not yet been born. There was no Defence Medical Association of Canada. There was no approval of schools for laboratory technicians and no Canadian Society of Laboratory Technologists. Nor had the Canadian Society of Radiological Technicians been set up. There was no Canadian Dietetic Association (1935) and, of course, hospitals were not approved or otherwise for dietetic interns. There were no schools in Canada for medical record librarians. The Standard Nomenclature, now almost the unanimous choice, had not been developed and hospitals, if they followed any at all, had a wide choice of systems.

The provincial medical associations were not then "Divisions" of the Canadian Medical Association as they are now, but were quite separate in organization. There was no Canadian Association of Radiologists (1937), no Canadian Ophthalmological Society (1937), no Canadian Cancer Society (1938), no Canadian Rheumatism Association (1936), nor a Canadian Arthritis and Rheumatism Society (1947). There had been, however, an active Canadian Tuberculosis Association since 1900 and a National Committee for Mental Hygiene since 1918.

Hospitals Not Well Organized

The hospital field itself, from the administrative viewpoint, was not well organized. There was no national hospital body. The Department of Hospital Service of the Canadian Medical Association, made possible by the generosity of the Sun Life Assurance Company of Canada, was not set up until January, 1928. Three years later the Department of Hospital Service sponsored the formation of our present national body, the Canadian Hospital Council, organized in September, 1931.

Several provincial hospital associations were in existence — in British Columbia ('18), Alberta, Saskatchewan, Manitoba, and Ontario. The latter body, the Ontario Hospital Association, had just been organized by a committee of

Obiter Dicta

Our regular pages of editorial comment under the heading "Obiter Dicta" have been suspended this month in view of the size of the anniversary issue and the preparation of other special material. Obiter Dicta will be continued again in March.

Contrast in Hospital Capacities

	1929		1946	
	No. of Hosp.	No. of Beds	No. of Hosp.	No. of Beds
Public General	481	32,218	584	60,512
Tuberculosis	31	5,655	94*	13,594
Mental	42	26,862	60	45,443
Chronically Ill	33	2,700	23	3,748
Federal Government	16	3,614	78	13,986
Municipal Hospitals (excl. isolation)	72	5,643	122	10,531
Proprietary	269	2,500	277	3,356
Total of all hospitals	886	74,882	1,078	141,451

*Including 49 tuberculosis units in other hospitals.

the Ontario Medical Association, as had also been the one Catholic Conference, the Maritime Conference. The Ontario United Hospital Aids was then in its 10th year. The Montreal Hospital Council was not formed until 1926, letters patent being taken out in 1931.

The parents of the Maritime Hospital Association ('43), the Hospital Association of Nova Scotia and Prince Edward Island and the New Brunswick Hospital Association, were not formed until 1929. The present Associated Hospitals of Alberta was formed only six years ago by the amalgamation of the Alberta Hospital Association ('19) and the Alberta Municipal Hospitals Association. Most of the Catholic Conferences were set up in the '30's and the Catholic Hospital Council of Canada was organized in 1943. The Prairie Provinces Conference of the C.H.A. was only divided into three provincial conferences in 1944. The first International Hospital Congress at Atlantic City was not to take place for another five years.

Actually we do not know how many hospitals or hospital beds there were in Canada in 1924. National statistics respecting hospitals had many omissions at that time. The first list (far from complete) was not issued by the Department of Pensions and National Health until 1926. This indicated a total of 28,076 beds. Then a revised list was issued by the Department in 1929 from material collected and prepared by the Department of Hospital Service of the Canadian Medical Association. For this development we should thank Dr. Helen MacMurchy, then of the Department of Pensions and National Health. The Dominion Bureau of Statistics took over in 1932, when it issued its first annual report of hospitals. The 1929 Directory, utilizing the best information then available, gives summary figures, some of which are contrasted on this page with corresponding figures from the Dominion Bureau of Statistics data for 1946, the latest available, (see Table).

Education in Administration

Educational facilities in the field of administration were distinctly limited. There were no "institutes" on administration, accounting, purchasing, construction, et cetera, either here or in the United States, the first being organized at Chicago in 1933. University courses in administration only began with the University of Chicago course in 1934. The American College of Hospital Administrators, which is doing so much to encourage sound administration, was not organized until 1933.

Group Plans

Although individual hospitals, as in Glace Bay, had had "check off" or prepayment industrial plans of hospitalization for some years, the first joint regional plan sponsored by Canadian hospitals was developed by the four general hospitals only in Edmonton in 1934. The first Blue Cross plan in Canada—the Manitoba Hospital Service Association — was established in 1937.

From this brief review it is obvious that today we are standing a long way from where we were twenty-five years ago. Although we may query certain features and details, it is obvious that these years have meant very distinct advances in our provision of hospital care. We hope that the next twenty-five years will witness as many and as substantial advances. From present indications they should prove even more fruitful.

Largely in Retrospect

A. F. Anderson, M.D.,
Formerly Superintendent, Royal Alexandra Hospital, Edmonton, Alberta.

WHILE congratulating *The Canadian Hospital* on the attainment of its twenty-fifth anniversary, permit me briefly to reminisce about the conditions prevailing in the hospital field, when Mr. Chas. A. Edwards had the temerity to launch his magazine in a noble effort to educate hospital workers toward the goal of greater and better community service.

We had survived the ordeals of the first world war with its aftermath of inflation and subsequent recession. We were in fact just entering upon some half-dozen years of general prosperity in the late '20's. Co-incident therewith a rather extensive era of hospital expansion was in vogue. The time was ripe for a general stock-taking of prevailing hospital conditions and evaluation of services rendered. The great influenza plague and many lessons emanating from the experiences of the Great War alone should have provided the stimulus, but in reality it was the birth of the American College of Surgeons, and its critical analysis of hospital services generally, that was chiefly responsible.

Dr. Anderson in action

Almost first to be brought into the limelight was the general lack of efficient staff organization, especially in hospitals not directly affiliated with teaching institutions. These "open" hospitals were subject to the whims and temperament of members of the medical profession, not all of whom had been subjected to the discipline of army life. In most instances, it required the co-operation of the Fellows of the American College of Surgeons with hospital administrators and trustees to overcome the prejudice and opposition of medical men, obsessed with the idea that license to practise carried therewith full hospital privileges,

with the right to throw their weight around, expecting the hospital personnel to do their bidding, and to accept their criticism and abuse without question. Well-organized hospital medical staffs, holding appointment at the pleasure of governing trustees and subject to rigid staff by-laws and regulations, have been achieved only after years of struggle and negotiation.

Numerous other features of prevailing hospital practice were also due for overhauling and improvement. In most instances staffs of graduate nurses were very limited and the supervisors were grossly underpaid. Nurses were generally working sixty hours a week and their remuneration was about sixty dollars per month. As an example of such conditions, one graduate staff nurse was expected to supervise several operating rooms with the sole assistance of student nurses who were required to scrub up for all operations, whether major or minor.

The great majority of confinements were still conducted in private homes with or without the assistance of the Victorian Order of Nurses. In the very limited maternity wards of hospitals, gas anaesthesia had not been provided and chloroform or ether during the second stage of labour was the order of the day. The attempt to introduce "Twilight Sleep" was unsuccessful in the main. The barbiturates had not been developed to any great extent while the sulfonamides were unheard of and penicillin was not even a dream. It is true that experimentation was being undertaken with the intravenous use of mercurochrome, but intravenous medication of all kinds was in its infancy, including even that of glucose and saline solutions.

Insulin had arrived but the organized diabetic clinic was still an embryo. Ward rounds were available only in teaching institutions and even these were restricted largely to medical students. Radium and deep x-ray therapy were as yet hardly available, with cancer clinics conspicuous by their absence. As a rule committees of the staff to supervise treatment of fractures, et cetera, were non-existent.

Iodine and picric acid were the usual agents used for skin sterilization. Ether, administered by the open drop method, was the prevailing anaesthetic. Ethylene had very limited use in Canada, although nitrous oxide and oxygen were being utilized. Anaesthetists had the temerity to use ethyl chloride, especially for induction purposes. Sodium pentothal and cyclopropane had not arrived, nor had spinal anaesthesia been resurrected. Specialization in anaesthesia had not progressed very far and for the most part the general practitioner monopolized the field without any staff organization in control.

Blood transfusions were few in number and generally considered a major operating procedure, utilizing the direct method as a rule. No one would think of giving iodine to a hyperthyroid patient nor were basal metabolism tests relied upon to a great extent. Electrocardiograms were a rarity. Wassermans on all admissions were not considered necessary nor advisable, much less routine chest x-ray films. Provincial venereal clinics had been established and tuberculosis sanatoria provided but the cancer problem had been largely neglected.

Bronchoscopy was in its infancy. Chest surgery was confined to a few specialists in large centres. The great advances in neurological surgery and many other fields were still of the future. No attempt was made to demand evidence of special training on the part of surgeons invading major fields of effort and, of course, the Royal College of Physicians and Surgeons of Canada had not been born.

Hospitals still bore more or less the stigma of "charity" and had not entirely overcome the prejudice of our large immigrant population with their aversion to the "poorhouse" in the old land. Even many of our native population strenuously preferred to be cared for at home in the case of illness. The great advantages of hospital treatment still had to be sold to the public. At the same time the privilege and necessity of paying their way while so domiciled had to be demonstrated to and impressed upon many. Governments —municipal, provincial, and federal—had to be convinced of the vital need of hospitals for financial assistance from taxation sources.

Meanwhile the tremendous advancement in the field of biochemistry with the production of so many new, powerful, and expensive synthetic drugs has added to the problems of the hospital administrator. Co-incident with this has been the necessary development of extensive laboratory procedures for the multitude of biochemical tests now required. These problems are not only financial headaches, but their multiplicity imposes on the hospital administrator and his staff a huge responsibility in their effort to assess and incorporate, when indicated, all these advances in remedial agents and equipment.

In the years since its inception, *The Canadian Hospital* has done much to help hospital workers in keeping posted on all new trends. Since the organization of the Canadian Hospital Council in 1931 the whole hospital field has benefited immensely from the counsel and guidance of its great secretary, Dr. Agnew; and when Mr. Edwards turned over his magazine as a going concern to the Canadian Hospital Council and Dr. Agnew was persuaded to assume editorial direction of it, *The Canadian Hospital* blossomed out as a real asset to hospitals from coast to coast. In closing, may I, as a retired hospital superintendent be permitted to predict a still greater and grander future for *The Canadian Hospital*.

Dr. Fiddes en route to Lisbon

Dr. G. W. F. Fiddes, medical superintendent of the Brandon General Hospital for the last two years, is en route with his family to Lisbon, Portugal. There he will take a special course in languages and tropical medicine and later will proceed to Dondi, in Angola, Portuguese West Africa, where he will spend five years as a medical missionary.

"Volume 1; Number 1"

THIS month *The Canadian Hospital* observes its silver anniversary. Mr. Charles A. Edwards produced the first issue as a private venture in February, 1924. True, for some months it bore the name *Hospital Buying,* but by November of that year it had shed its baby clothes and had taken the broader title of *The Canadian Hospital.*

It is most interesting to look over "Volume I: Number 1" of twenty-five years ago. That modest issue contained but 20 pages, including front and back covers. Mr. Edwards' office was then down at 13 King Street West in Toronto. A number of firms advertising in that issue are still regular advertisers and have been consistently so down through the years. Major contribution was an article by Mr. W. L. Somerville, the well-known architect, on "The Small Hospital"—the "first of a series of articles on planning, building, and equipping the small hospital".

Items in the News

A number of news items and editorial comments are of much interest today.

For instance, the Western Hospital of Montreal had just become amalgamated with the Montreal General Hospital, becoming the Western Division of that hospital. Much credit was given to its President, Mr. John C. Newman, for the progress of the hospital under his chairmanship.

The Ontario Hospital Association had just been formed. Officers elected were:

President: Col. Wm. Gartshore, London.

Vice-presidents: Mrs. H. M. Bowman, Toronto; Dr. Edward Ryan, Kingston.

Secretary-treasurer: Dr. F. W. Routley, Toronto.

Directors: Dr. J. H. Holbrook, Hamilton; E. K. Loughlin, London; T. Pratt, Hamilton; Major Moncrieff, Petrolia; Miss Elizabeth Whiting, Cornwall; Mrs. J. K. McArthur, Owen Sound; Miss E. M. Dickson, Toronto; Inspector James Govan, Provincial Government.

At the organization meeting considerable doubt was expressed about the value of standardization, particularly to the smaller hospitals, and the sentiment of many of the representatives was that they would have to be shown whether it would be an advantage or a disadvantage to them.

The Shriners' Hospital in Montreal, "to be erected and maintained in perpetuity without public subscription by the Ancient Arabic Order of the Nobles of the Mystic Shrine", was under construction. Figures were quoted to show that the Shriners' Hospital had ample funds to provide for operation.

The Ste. Agatha Sanatorium had just been taken over by the Quebec Government.

Doctors in Sandwich, Ont., urged the building of the new proposed hospital (Metropolitan). The Border Cities had but 2.3 beds per 1,000 population, while London had 11.2 and Ottawa 9.8.

St. Joseph's Hospital, Toronto, was about to add 45 beds, thus making a grand total of 150 beds. (The hospital now has 308 beds and 43 bassinets.)

A $100,000 fire had occurred at the Hospice Gamelin, Montreal, on January 4th.

The Methodist Church Hospital at Vita, Man., had been opened in December, 1923. A population of 8,000 in the region, largely non-English-speaking, was living from 15 to 60 miles from the nearest physician.

When we come to our fiftieth anniversary in all probability readers at that time will find it of unique interest to reminisce over the happenings back in February, 1949.

Further Progress

It was not until 1936 that *The Canadian Hospital* became officially linked with the Canadian Hospital Council, although very close relations had been established for several years. At that time the Council took over the editorial direction under the late Leonard Shaw, then superintendent of the Saskatoon City Hospital. When Mr. Shaw became assistant secretary of the American Hospital Association in 1938, Dr. Harvey Agnew took over on a temporary basis and is still editor.

In 1941, Mr. Edwards very kindly offered to turn over his financial interest in the Journal as a gift to the Council. Because of limited staff and pressure of work, this offer could be accepted only on the basis of continuing the already existing financial arrangement. Finally, in 1947, it was possible for the Council to take over the full ownership and operation of the Journal, Mr. Edwards retaining his position as business manager, a responsibility which he is discharging most admirably as this issue bears evidence.

Twenty-five Years of NUTRITION

E. W. McHenry, M.A., Ph.D., F.R.S.C.,
University of Toronto.

SO much emphasis was placed on nutrition during World War II that some people gleaned the impression that the subject had been discovered recently and its principles were being applied for the first time. Such, of course, was not the case. Nutrition is an old brand of science. About the first report of a controlled investigation in human nutrition is in the Old Testament. The fundamental observations which made possible modern nutrition were made in the 18th century. Twenty-five years ago most modern concepts were in existence and nutrition was recognized in the public health field. An instance of the type of interest then in vogue can be found in an examination held in the School of Hygiene of the University of Toronto for public health students. One question was, "Discuss the experimental evidence which establishes the existence and the physiological significance of the substances termed vitamins". It is useful to consider the implications of that question posed in 1924 and to review briefly advances since that time.

In 1924 there was evidence establishing the existence of five vitamins and the examiner obviously had no doubt about the evidence nor about the vitamins being actual substances. Today the existence of at least *eighteen* has been verified. The chemical composition is known for twelve or more and most of these have been synthesized in the laboratory. In 1935 pure thiamin could be purchased in small quantities at $150. per gram; now it is manufactured by the ton and is available for a few cents a gram. Twenty-five years have seen great advances in knowledge of the existence of vitamins and of their chemistry. However, the second part of the 1924 examination question, that dealing with the physiological significance, can not yet be answered adequately. It is known that the B vitamins act as components of enzyme systems, but there is little precise information regarding the function of these substances in human metabolism. There is, indeed, considerable disagreement about quantitative human requirements for even the B vitamins. Functions of other vitamins can be described in general terms but the exact mechanisms of action are unknown.

With the advent of knowledge of the vitamins and, more particularly, when concentrated preparations and pure substances became available cheaply, there arose tremendous enthusiasm and wide-spread commercial efforts to profit from the new field. It is estimated that several hundred million dollars are spent each year on this continent for vitamin preparations. Considerable doubt may be expressed as to whether this is an advance or whether it is even desirable. Despite evidence that vitamin D will not prevent the common cold, the public is still urged to use it for that reason. One frequently hears of prescriptions of large doses of thiamin for patients with vague aches and pains, despite a lack of evidence that any good could be expected. It would be interesting to speculate how much money is wasted in Canada for the unnecessary purchase of vitamin preparations, both on prescription and otherwise.

Many items of progress in nutrition in the past twenty-five years could be cited. A number of investigations have shown the value of adequate nutrition in pregnancy, not only for the mother but for the infant as well. Recent studies indicate that nutrition plays a role in the prevention of several abnormalities of pregnancy. Twenty-five years ago the deficiency disease, pellagra, was a major cause of insanity and of death in the southern United States; it has now practically disappeared from that region. During the recent war many British troops in India succumbed to sprue; a specific treatment for the disease is now available.

While these and other advances could be cited, it should be remembered that nutrition is a branch of science in which a large amount of research is proceeding. It would be expected that new knowledge would supplant old and that concepts once believed to be true have been found erroneous. The evangelistic publicity regarding nutrition during the recent war gave the impression that nutrition was a closed book and that nutritional knowledge was final and complete. This, of course, is not correct. The war and its aftermath provided several illustrations of previous concepts being invalid. For example, it was expected that the wretched inmates of the German concentration camps would exhibit severe vitamin deficiency diseases. They did not do so and it was apparent that marked calorie restriction is more damaging than deficiencies of the vitamins.

During the past twenty-five years there have been many advances and re-adjustments in nutritional knowledge but a discouraging aspect has been the continuous failure to apply the knowledge. Several Canadian examples could be given. The efficacy of iodized salt in the prevention of endemic goitre has been known for a quarter century yet *only half of the table salt used in Ontario last year was iodized.* It could be added that some health officials seem reluctant to have this knowledge applied. The specific preventive of rickets, vitamin D, has been known for the same period, but recent surveys in Canada have shown that about 10 per cent of school children have bone abnormalities resulting from rickets and that only a small proportion of school children receive adequate supplies of this needed vitamin. As a final Canadian example of the failure to apply nutritional information, one may ask how many Canadian hospitals have profited from the excellent study done during the war by members of the R.C.A.M.C., on the waste of food, and the effect upon patients resulting from poorly prepared, im-

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25 Years of Progress in the CLINICAL LABORATORY

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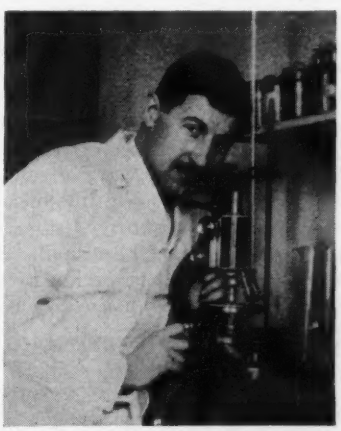
THE practice of medicin is vastly more scientific than it was twenty-five years ago. Laboratory medicine, since it is the basis of scientific clinical medicine, has shown, perhaps, greatest development in character and scope. We, who work in laboratory medicine, are at times embarrassed by the extent to which the clinician relies on the laboratory, and our staffs are, at times, overloaded with laboratory work, much of which could be eliminated by a more careful preliminary physical examination of the patient. It does happen on occasion, that a clinician will not look at a patient until a complete course of routine clinical laboratory procedures has been carried out, but fortunately this attitude tends to fade. It is mentioned to indicate the degree to which the clinical laboratory service, over the years, has become indispensable to the practice of medicine.

Today even the smaller hospitals must have either a well-equipped and adequately staffed clinical laboratory, or access to such service. The modern hospital, thanks mainly to clinical pathology, is much more than a nursing and therapeutic institution; it must be a seat of scientific diagnosis and of scientifically applied therapeutics, medical or surgical. Advances in the scope and character of the work of the clinical laboratory over the past twenty-five years have been little short of phenomenal.

The experience of the Department of Laboratories of the Hamilton General Hospital (over which department the writer has presided for over 30 years) is an experience common to all of the larger hospital laboratories and will illustrate the trend. Twenty-five years ago the Hamilton General Hospital had about 500 beds. When current construction is completed, it will have nearly 1,000 beds. Under the conditions of pressure on hospital accommodation which have obtained for the past ten years, the patient turnover per bed is probably double that of twenty-five years ago. In 1923, patients had to be persuaded to come into hospital; in 1948, the pressure made it necessary, on occasion, to persuade them to stay out. This is mainly due to public recognition of the increasingly scientific character of hospital service and, also, in no small degree to the advance and expansion of clinical laboratory service.



The director in his one-room laboratory in 1919.

Tremendous Expansion

In 1923-4, the laboratories of the Hamilton General Hospital were housed in three rooms, with a floor space not exceeding 1,500 square feet. The staff consisted of the pathologist, three technicians, and a clerk. In 1925, new quarters were built, with a floor space of 4,000 square feet, and the staff then consisted of the pathologist, five technicians, a clerk, and an orderly. Today, with the completion of current expansion, the laboratories will occupy nearly 10,000 square feet of space. The staff, none too large at present, will be comprised of the pathologist, five interns, eighteen technicians, three secretaries, three blood bank staff, five intravenous nurses, four laboratory assistants, and twelve students in medical technology, a total of *fifty-one* workers in the department. And this staff and space are adequate only for the present requirements of the clinical laboratory service of the hospital and the laboratory service of the City Board of Health. The laboratories are jointly hospital and Board of Health laboratories, the Hamilton General being a municipal institution.

By 1924, the range of service given by the clinical laboratories had begun to assume its present form. Autopsy service and surgical pathological diagnosis had been long established as among the fundamentals of clinical laboratory service. Urinalysis, with chemical estimations of the nitrogenous and other chemical constituents of the urine, was still relatively important. But pathological chemistry, as a routine clinical laboratory service, made possible by the development of the colorimeter, was beginning to assume the importance which it has today. The level of the chemical constituents of the blood has much more clinical significance than the degree to which they are excreted in the urine. Haematology, in the early days, covered mainly the estimation of red cells, haemoglobin, and white cells. Bacteriology covered the isolation and recognition, for diagnostic purposes, of the common organisms, which have an etiological role in infections and infectious diseases. Sulpha drugs and penicillin had not emerged to complicate the search. Bacteriology's hand-maiden, serology, was already a child of lusty growth, but confined its activities largely to agglutination reactions, the now somewhat out-moded opsonin index, the relatively new Wasserman reaction for syphilis, the simple typing

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properly served, and badly timed meals? Perhaps in the next twenty-five years it will be realized that appetizing, nutritious meals are an important factor in therapy and in convalescence. While much of the field of nutrition remains to be explored, *the principle need today is the general application of existing information.*

of blood into its four groups (Moss or Jansky nomenclature) for indirect or direct transfusions. Blood banks had not yet been devised. Basal metabolism estimations were new and were usually carried out by the laborious Tissot spirometer method. Knowledge of hormones was in its infancy and no practical methods for hormone estimations were available outside of research laboratories.

In 1923, the clinical laboratories of the Hamilton General Hospital carried out a total of some 25,000 clinical laboratory investigations. In 1948, the total was about 250,000—ten times greater. The variety of types of examinations also showed a ten-fold increase.

Dr. William Deadman To-day

Pathologic Chemistry

Perhaps the outstanding development has been in the field of *pathologic chemistry*. In its infancy, twenty-five years ago, it was largely confined in routine clinical laboratories to the estimation of glucose and nitrogenous elements, urea, creatinine and uric acid. Today the estimation of chlorides, cholesterol, calcium, and phosphorus in the blood are commonly called for, and are part of the routine service. The study of the protein fractions of blood plasma, such as serum globulin and serum albumen, gives valuable information in certain types of disease. Estimation of total blood iodine in goitre is of great assistance. The study of serum bilirubin by means of the Vandenberg test contributes very materially to the knowledge of liver disease and of liver function. Estimations of serum hormones, impossible in the routine clinical laboratory twenty-five years ago, are now routine procedures. Acid phosphatase and alkaline estimations are helpful in the diagnosis and prognosis of cancer of the prostate; serum anylase estimations are of assistance in the diagnosis of acute pancreatitis. Estimation of alcohol levels in blood and urine have been of great service to the Courts, particularly in cases arising out of automobile accidents. These are but a few of the procedures developed over the period.

The 1948 graduating class of technicians at H.G.H. Centre, Mr. F. J. Elliott, Past President, C.S.L.T.

Bacteriology

In the field of *bacteriology*, great advances have been made in the classification of bacteria and in the typing of certain of them, such as the streptococcus and the pneumococcus. Twenty years ago, pneumococcus typing was one of the onerous and responsible tasks of the clinical laboratory during the winter season, since the therapeutic use of the correct type of antiserum depended on it. But with the introduction of the sulpha drugs and later of penicillin, the use of serum declined and a new task of measuring the susceptibility of various bacteria to the action of these antibiotics devolved upon the laboratory. New knowledge of viruses and the introduction of the electron microscope brought in the estimation of serum antibodies of antiviral character, but as yet these estimations have not become routine except in the larger central laboratories.

Serology

In the field of *serology*, there has been marked expansion and development. Modifications of the original Wasserman test have brought in greater accuracy and better quantitative methods. The introduction and development of the Kahn test, with its various modifications, and of flocculation tests, has greatly speeded up the laboratory diagnosis of syphilis and provided more or less rigid checking for the Wasserman test. Transfusion service has been improved and reactions more and more controlled by the typing of bloods, not only for the four original types but for an increasing number of subtypes; the introduction of typing for the Rh factor has been a boon to the practice of obstetrics. The establishment of blood banks in hospitals, a development of the last fifteen years, ordinarily under the aegis of the clinical laboratory, has imposed added responsibility on the laboratory director and his staff, and has greatly accelerated the speed with which suitable blood for transfusions can be supplied.

There have been marked advances in *haematology*. The estimation of the sedimentation rate is now a firm-

(Concluded on page 103)

Twenty-five Years Bring Changes to B.C. Hospitals

In the past twenty- five years, although the number of British Columbia hospitals has increased but slightly, the number of beds has nearly doubled; the average stay has been materially reduced; costs have gone up 50 per cent; the number of schools has been cut to one quarter; student nurses have increased 50 per cent; and the number of nurses graduated has risen to 1,525. We are indebted to Mrs. Edith Pringle, Inspector of Hospitals and Institutions for this information.

With respect to the figures shown Mrs. Pringle adds the following comment:

1. Figures prior to 1938 may not be strictly comparable to figures from 1938 to 1947. Basis of calculation, et cetera, different.

2. Drop in bed capacity 1941 due to Government checking capacities.

3. Schools of nursing are approximate only prior to 1936. Number of pupil nurses and graduate nurses given as there is no record of graduating classes but ratio might prove interesting.

B. C. Hospitals, 1924-1947

Year	General Hospitals	Beds	Length of Stay	Per Diem Cost	Schools of Nursing	Pupil Nurses	Total Grad's
1924	63	3,194	14.5	4.44	27	713	267
1925	64	3,363	13.5	4.27	29	737	270
1926	69	3,501	14.3	4.18	30	823	319
1927	68	3,678	15.6	3.90	32	882	348
1928	68	3,768	15.6	3.79	36	908	388
1929	67	4,168	15.5	3.86	32	911	502
1930	68	4,289	15.4	4.52	31	913	499
1931	67	4,577	15.5	4.03	28	880	548
1932	69	4,508	15.9	3.51	26	772	584
1933	70	4,600	15.7	3.20	27	751	605
1934	71	4,760	15.2	3.24	25	706	670
1935	70	5,091	15.0	3.26	21	753	766
1936	70	4,452	14.5	3.37	21	820	838
1937	68	4,546	13.6	3.58	12	775	884
1938	72	4,778	13.2	3.66	8	836	872
1939	76	5,013	13.2	3.78	7	918	961
1940	76	5,107	12.8	3.78	7	974	1,079
1941	78	4,861	12.8	4.00	7	1,004	1,079
1942	79	5,062	12.2	4.09	7	1,032	1,084
1943	77	5,274	11.9	4.53	7	1,098	1,219
1944	77	5,218	11.9	4.88	7	1,089	1,249
1945	76	5,307	11.5	5.17	7	1,081	1,409
1946	78	5,427	10.7	5.49	7	1,011	1,438
1947	75	5,650	10.2	6.67	7	1,124	1,525

Changes Also in Ontario Since 1923

Mr. George Davis, chairman of the Health Survey Committee in Ontario, has furnished us with this interesting table of comparisons between 1923 and 1947, the latest available statistical analysis. It is realized that in some instances the basis of calculation may have changed over the years.

	1923	1947
Beds, General Hospitals (incl. Red Cross)	8,983	14,533
Number of Hospitals	118	146
Average length of stay	18 days	10.5[1]
Beds in Sanatoria	1,543	3,735
Beds in Hospitals for Incurables	409	1,643
Patients cared for in Gen. Hosps.	139,719	548,445[2]
Patients cared for in Tbc. Sans.	3,146	6,460[3]
Average per diem cost (Gen. Hosps.)	$3.19	$7.27
Dietary cost per patient per diem	$0.77[4]	$1.16
Infants born in hospital	13,123	89,516
Payments by patients for care	$4,336,337	$28,130,037
Gov't. grants for care	$649,876	$1,836,878
Gov't. grants to Sans. (care)	$296,549	$3,367,270
Municipal payments (Gen. Hosps.)	$1,671,072	$3,779,519
Total expenditures of Hospitals for maintenance and equipment	$8,091,803	$35,169,717

1. Based on patients discharged rather than patients treated.
2. Patients discharged in public general and Red Cross hospitals totalled 519,667.
3. Admissions were 3,151 and discharges 2,422.
4. Raw food costs only.

Dancing Hormonies

The story of two little autacoids*, who back in 1923 started upon their long-anticipated career of nursing.

By a One-Time "Probie"

AS we passed along the streets of a strange new city, we heard the queer rumbling noises of street cars, the screeching brakes of the model-T Ford halting at the sound of the policeman's whistle, and the raucous cry of the Italian fruit vendor making known his wares from atop his horse-drawn wagon. It was a singular contrast to the quiet little town street on which we recently had led a routine and sheltered existence. Our effervescence was uncontrollable—here was life, but what did it hold for us?

The entrance to the very large building, the hospital, was approached by a long walk past grounds carefully protected by tall iron pales. We settled ourselves to a modestly slow

pace. Finally we turned in between large brick pillars and began climbing the cold concrete steps leading into the vestibule. No soft green ferneries greeted us as they do today, but we danced a step or two as old Tom, the elevator man, with a sparkling eye directed our faltering steps to the office of the superintendent of nurses—later known as the T.S.O. Here we were met by a scrutinizing gaze above a mass of starched white apparel. After "checking the list", and us too, we were directed along what seemed miles of corridor to the place we had tried to visualize from the calendar picture, the nurses' residence. Again, over the austerity of a uniform, we were appraised by a quick and critical glance, then transferred to the kindly ministrations of a sympathetic blue uniform. Recognition of a kindred spirit caused us to take on a two-step, as we were transported by elevator to a room which was to be the centre of ballet for three years. Here were the regulation four white beds, four green walls, and an immaculately scrubbed white floor. As we were the first arrivals it was our privilege to stake out the first claim. Our pride of title, after selection of our corner, carried us back to the possessive feeling which we imagined Cartier must have experienced as he erected the fluer-de-lis on the shores of Gaspé almost four centuries before. At this point we joined hands in the Scottish Reel.

From sound slumbers, at six the following morning, the clanging of a bell brought us to consciousness. In the dusky morning light we actively took our allotted corners in an endeavour to appear, according to previous instructions, in the clothing of a "probie". From the entanglement of the hair net, we came to the elusive collar buttons which held together the clerical collar of the novice uniform. With increased effort and speed and with sixty inches of laces, we finally tied up the high black shoes. Then out came the measuring rule to check carefully the twelve-inch floor clearance of the uniform, the one-inch showing of the uniform below the billowing folds of the starched white apron, and the six-inch gap between bib and collar. (We later found that this regulation should have been deleted from the standard requirements and that this gap was quite obsolete.)

For six months we carried on our duties according to instruction. Never before had we seen so many gleaming white beds carefully "toed in" in an absolutely straight line by a thirty-yard cord roll. Under the uncomfortable covers in those beds lay still, white figures, afraid to move, if able, even at the stimulation of a fellow hormone. We were becalmed while the "great white group" passed by at exactly nine o'clock, speaking, as it were, in a bewildering and foreign language. Then slowly we took on our former activity and to the lilting strains of "Tip Toe Through the Tulips" we disappeared, only to

We regret that the author of these delightful and nostalgic reminiscences prefers to remain anonymous, but we may note that she is now a highly competent praeceptor and a recognized authority in the hospital field.

**An "autacoid", in this instance, might be defined as either an exciting "hormone" or a restraining "chalone" in the chemistry of body reactions. Any apparent reference to the stimulating influence of these neophyte hormones on others, particularly nursing superiors and interns, is purely coincidental.*

Collecting Data for the Monthly Cockroach and Mouse Report.

emerge in the basement classroom, once more our normal selves.

Day after day passed, beds alternating with cold classrooms unrelated to practical work. One fine spring morning we were swept off in a waltz with a willow basket, containing bottles, whisk, and other toilet equipment, to give a bed bath. Our female patients prided themselves on their long tresses, which it was our duty to plait carefully. To accomplish those smooth braids was quite a feat, but with practice we eventually acquired the art of producing the desired glossy, neat appearance on our Lady Godivas. Outward appearance of the patient was far more indicative of good nursing than the understanding of her inward needs.

It was only when we began to settle into our routine that the responsibility of "reporting" was bestowed upon us. We were to be included in a piece of kitchen research in the form of observing and recording for the weekly "cockroach and mouse report". This sent us into an old-fashioned square dance, for it was "swing your partner and away to the left" at the very first sight of either offender. The accuracy of our reports was never questioned, and we were left to reason why the results of our diligent, if distraught, search were never noted.

At the end of six months it was our hope that we had experienced everything. On the day those fragile and long-anticipated bits of finery were pinned upon our self-haloed heads, we thought nothing was left for us to learn. We had conquered our rivals, the sympathetic neurones, and we could count and sort ten bags of soiled laundry immediately after our breakfast; we could separate and save all the gauze from those used dressing pads before dinner; we could slip blissfully off to sleep in the first five minutes of any doctor's most interesting lecture (unless it was our turn to take the notes); we knew every doctor by his tie. Moreover, we could "do up" twelve patients before nine o'clock in the morning, if we had a good start and no interruptions, and we were gradually acquiring greater dexterity with four thermometers for thirty patients. Soon we would have the responsibility of thirty patients for the entire night.

Then one day old Mrs. Jones lost her teeth. She was one of our twelve, and had "just taken them out while she ate her dinner". She had wrapped them carefully in a bit of paper "off that roll" and "just laid them on her tray until she finished". She had gone off to sleep after her sumptuous repast and missed them four hours later. From the bedside table to the bed we went, then to the kitchen to peer cautiously into the empty garbage can. We took another look —had they gone as far as the incinerator? No, we had been told that all the food garbage was sold to a farmer. Perhaps we would have a trip to the country on this fine June day. But instead we were confronted by the largest garbage tin made, and hopefully went to work at the back of the huge building which they called "the plant". Fortunately, the molars were found, went through the process of "carbolization", and were returned intact and pure to dear old Mrs. Jones. On another occasion, Grandpa, our pet of the ward, carefully removed his lowers while having supper; in the dusk of the late afternoon they were unnoticed by us, and forgotten by him, as they hung on the top bar of his bed, almost a good luck omen for him, but causing many searching moments for us.

In an amazingly short time after receiving the cap, we were advanced to the responsible position of "pantry nurse". Those were the days when the day nurse arrived on duty to find the patients wide awake, having partaken of their breakfasts at 6.00 a.m. To accomplish this it was our moral obligation as pantry nurse to report for duty at 5.30 a.m., even though half asleep and hastily pinning on the last-acquired bit of uniform, the cuffs. We were faced with the task of preparing sixty breakfasts in half an hour, serving and feeding the drowsy occupants of the beds, and returning all trays to the kitchen before the arrival of the day nurses.

It was about this time that the short-style coiffure became the centre of attention. One or two of our fellow bravos had already had their tresses shorn, but during "on duty" time this fact was carefully concealed by well-matched switches. With envious eyes we watched the simplicity and ease with which a "bun" was attached securely at the nape of the neck, and held firmly in place by a hair net, while the cap, at a slightly backward angle, reposed cunningly over all. Against firm rules and regulations, one by one my fellow bodies succumbed, and finally we became involved in the war dance. With never a back step we went to the chief executioner's chair. One hour later we presented half the class with a "bun" of real hair to replace the heterogeneous mass of bunched together old hair nets (much cheaper than the switch), which satisfactorily camouflaged many bobbed heads. To our superiors the question of action against this disregard of orders was a problem. The "bob" stage certainly was worse than the "bang" stage.

(Concluded on page 93)

Yesterday, Today, Forever—The Problem of Lost Teeth.

AU COEUR DU PROBLEME HOSPITALIER

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IL semble qu'il soit possible, aujourd'hui, de reconnaître à l'évolution hospitalière trois phases, qui, sans être nettement tranchées, ont été assez caractérisées pour les distinguer l'une de l'autre. Sans avoir été spécifiquement voulues ou recherchées, elles se sont succédé, imposées qu'elles étaient par les circonstances de temps et de lieu.

La première de ces phases est retraçable à l'hôtellerie du bon samaritain où les soins au malade devaient avant tout être le désintéressement charitable et quelques menus pansements.

A cette phase première, succéda celle qui dure encore et qui peut porter le nom de "phase académique". Elle est reconnaissable par l'organisation de l'hôpital en fonction de la recherche du diagnostic surtout. C'est la course à la spécialisation, au perfectionnement de l'outillage scientifique. Elle dure encore et rares sont les signes évidents de forte décadence ou de substitution. Malgré cette permanence elle n'a pas su résister à une certaine compression au profit d'une troisème phase dite "hospitalière".

Phase Hospitalière

Cette troisième phase s'est insinuée petit à petit, et il faut se demander si, elle n'est pas devenue la première en importance. Légitimement réservée, dès son apparition, à une classe privilégiée, il fallut sans tarder l'étendre à tous les malades dont l'égalité humaine primait toutes les autres. Bientôt, à cause de cela, furent confondus "service hospitalier" et "service d'hôtellerie"; cela, il va sans dire, pas toujours à l'avantage des malades ou de l'institution hospitalière. Le premier des désavantages saute aux yeux. Ce nouveau type de malades exige et requiert des services dont la majeure partie n'est pas nécessairement médicale, et qui impose à l'institution un surcroit d'aménagement et de personnel. Cette onéreuse surcharge est alors reportée sur les frais encourus par la maladie même, frais pourtant déjà suffisamment lourds.

Le personnel est absorbé par ces besognes, déviées de leur orientation primitive, et cette déviation ne saurait être un acquis au but hospitalier poursuivi par l'institution. La légitime course au mieux entre les diverses institutions hospitalières ne tarde pas à multiplier et à intensifier de tels désavantages. Chaque hôpital cherche à égaliser l'autre et, de cette concurence, si loyale qu'elle soit, sont nés les palais modernes où sont rarement sur un même pied charité, confort et compétence technique envers le malade. Il est entendu que les efforts de tous convergent pour assurer aux malades cette triple satisfaction, mais combien peu y parviennent, la bonne volonté ne pouvant à elle seule en assurer la réalisation.

L'Agrandissement de l'Hôpital

Il est inutile de vouloir aujourd'hui réagir contre un pareil état de chose intimement lié à l'évolution du siècle. Le malade est habitué à cette ambiance et ce qui était une faveur est devenu une exigence. Il s'est familiarisé de plus en plus avec la notion d'un séjour à l'hôpital, cette maison étant devenue plus confortable et plus accueillante. La première conséquence de cette meilleure connaissance de l'hôpital fut, on le devine, l'accroissement du nombre des hospitalisés et cette conséquence devait constituer une des causes premières de l'encombrement hospitalier.

Parallèlement à cette invasion affective de l'hôpital, s'en établit une, de nécessité, imposée par les rapides progrès des techniques de diagnostic et de traitement. A cette seconde invasion, non seulement ont participé et adhéré les

Skiing in Quebec

malades, mais aussi les médecins et nombre d'autres organisations intéressées à la santé de l'être humain comme les caisses d'hospitalisation, qui sous de multiples formes veulent venir en aide soit aux malades soit aux hôpitaux en les allégeant d'une partie du fardeau.

Rien n'indique que cette cohésion soit sur le point de décroître et il faut se demander plutôt si elle n'est pas en train de constituer un monopole dont la puissance sera celle d'une centralisation à laquelle rien ne résistera.

Cet ensemble de circonstances ne constitue pas seulement un danger mais vient rapidement grossir le fort courant qui envahit l'hôpital et qui a déjà commencé à le submerger.

La Nécessité du Personnel

La solution s'imposait, il fallait agrandir; et ce fut fait. On ne tarda pas à se rendre compte que l'agrandissement d'un hôpital n'est pas seulement un projet d'ordre physique qui consiste à augmenter le nombre des lits, mais qu'il faut aussi accompagner cette extension numérique et spatiale d'un accroissement du personnel spécialisé et autre. Actuellement, cet accroissement est rendu de plus en plus difficile et empêche à lui seul la légitime et nécessaire extension de l'oeuvre hospitalière.

On ne peut remonter à la cause première de cette rareté du personnel sans faire tant soit peu allusion à l'évolution de l'humanité en général. Celle-ci a cherché dans la science la satisfaction de tous ses besoins au lieu d'y chercher la guérison de son ignorance. Elle a crée des échelons académiques que s'ils permettent une sélection de base, n'en comportent pas moins un accroissement indéfini des connaissances professionnelles. Et il ne faudrait pas s'en plaindre.

Comme les hôpitaux exigent de leurs étudiantes une scolarité avancée, ils ne peuvent pas s'attendre à ce que leurs élèves n'exigent pas un cours en progression constante. Au terme de cette progression, elles exigeront non moins légitimement un couronnement à leurs études qui les rendra aptes à occuper des positions incompatibles avec le cadre, qu'elles croient trop étroit, de la chambre du malade. Consacrer leur vie et faire tout un cours pour "soigner" un malade leur paraît disproportionné et rien d'étonnant à ce qu'il y ait plus de démissions que d'adhésions.

Une Solution

Faut-il revenir en arrière et moins exiger des candidates à la profession d'infirmière, ou ne vaudrait-il pas mieux entraîner dans les hôpitaux un double personnel? Cette dernière solution paraît plus logique et elle a déjà rencontré une grande faveur aux Etats-Unis, puisque en 1947 l'Etat de New-York à lui seul comptait déjà 109,000 "practical nurses". Il est temps que nos hôpitaux de la Province de Québec songent à cet aspect particulier qui assurerait suffisamment l'efficacité hospitalière. Si jusqu'à présent nos hôpitaux ont suffi et survécu, c'est qu'ils avaient été fondés sur une mystique accessible à des âmes d'élite seulement dont le recrutement était satisfaisant; mais aujourd'hui on constate une déplorable décroissance dans ce recrutement et comme se multiplient les centres d'activités, il faut chercher à combler cette lacune. Il doit exister, à n'en pas douter, dans le monde un nombre considérable de personnes qui voudraient encore se dévouer au soin des malades. Elles n'ont pas, il va sans dire, de grade académique, mais elles ont sûrement l'académisme du coeur et de la charité. Elles attendent l'occasion de mettre en oeuvre cette magnifique disposition naturelle que les malades préfèreront toujours à la froideur, à l'indifférence, voire au refus de services. Jamais une scolarité n'a réussi à assurer la merveilleuse convergence d'une charité vécue et d'une culture poussée qui réglerait une fois pour toutes le problème. Les exemples ne manquent pas où le dévouement n'est pas toujours au haut de l'échelle. Durant la dernière guerre, on a constaté quelle perfection de service avaient pu atteindre des aides bénévoles à peine formées. Pour changer un lit, présenter un cabaret, prendre le pouls, enrégistrer la température, est-il nécessaire de posséder des années d'entrainement et toute la hiérarchie des diplômes?

Ce plan de deux équipes de formation et d'attributions distinctes peut présenter à cause de la concomittance quelques difficultés techniques. Mais ces difficultés se révèleront assez importantes comparativement à l'importance des services acquis aux malades et à l'institution hospitalière dispensatrice de soins de première qualité.

Tout n'est pas encore écrit sur l'encombrement hospitalier et il sera toujours très difficile d'épuiser le sujet. Il semble que ce soit une de ces fatalités qu'il faille accepter et que l'on ne la fera pas disparaître en évitant d'y penser. C'est un problème d'envergure qui fait

(suite en p. 101)

Canadian Hospital Council to Meet in Quebec City

Dates May 26, 27, and 28.

The Canadian Hospital Council will meet in Quebec City on Thursday, Friday, and Saturday, May 26, 27 and 28. Sessions will be held at the Chateau Frontenac, one of the world's most picturesque and well-appointed hotels.

It is hoped that all hospital associations and conferences, all provincial, and the federal, governments, and the Blue Cross plans will be well represented. This meeting is being called in May rather than September because of the many important matters developing at the present time.

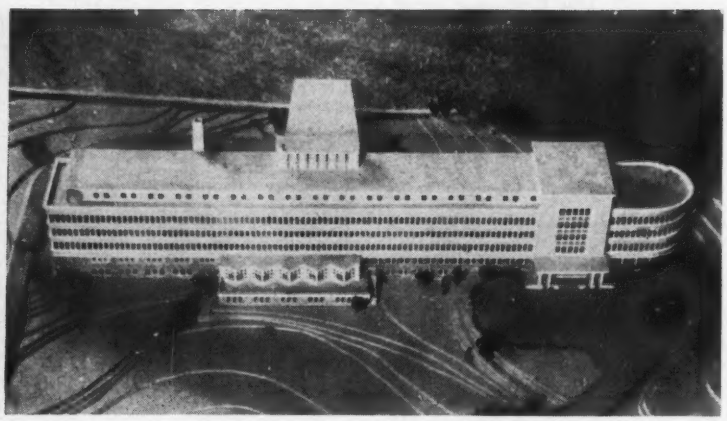
This is the first meeting of the Council to be held in Quebec City. The occasion offers an excellent opportunity to visit this unusual old city, to see some of its unique historical and military treasures, and to enjoy the wonderful panoramic view from the Dufferin Terrace and the hotel.

Attendance is not limited to official delegates, any person taking an active part in hospital work being welcome to attend any or all of the sessions.

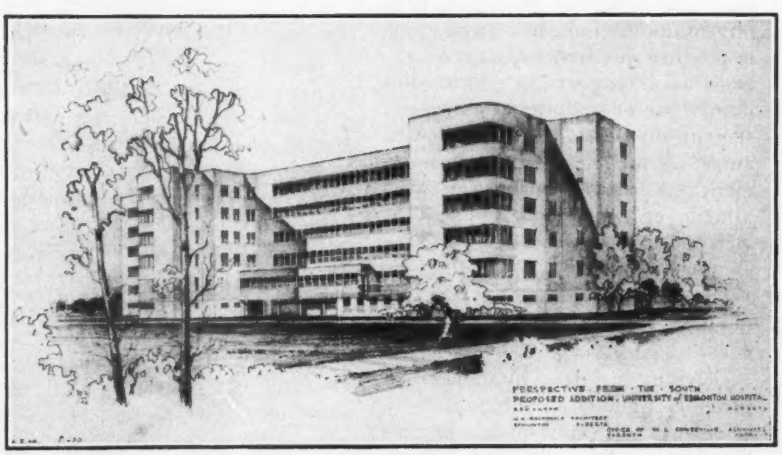
Some of the

NEWER CONSTRUCTION

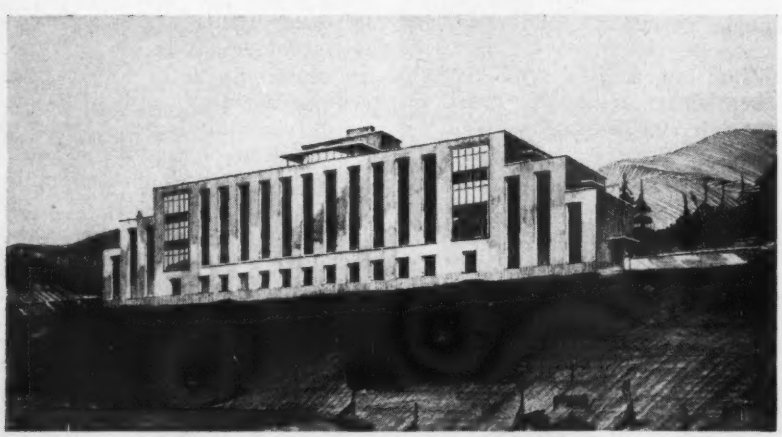
from Coast to Coast



Sanatorium Bégin, Ste. Germaine, Que. Capacity, 300 patients. Under construction. Architects, Mainguy and Rinfret, Quebec City.



University of Alberta Hospital, Edmonton, six-storey addition. Capacity 340 beds and 72 bassinets. Under construction. Architect, G. H. MacDonald, Edmonton; associate architect, W. L. Somerville, Toronto.



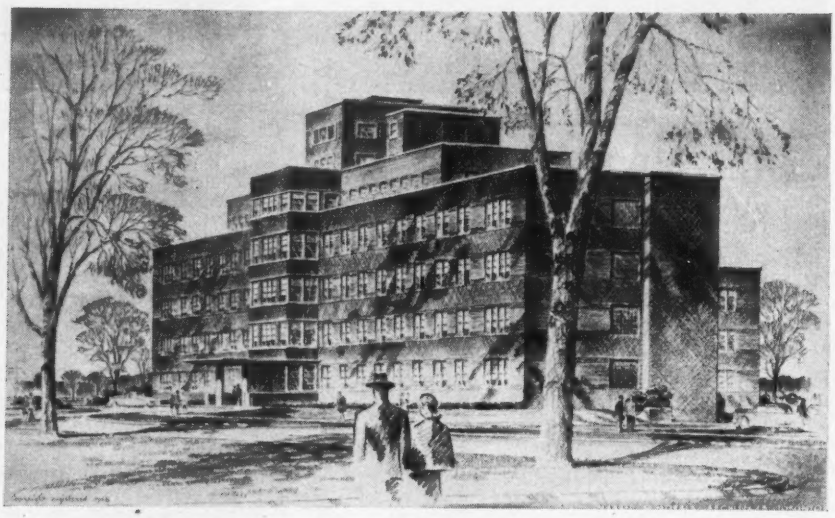
Western Memorial Hospital, Corner Brook, Nfld. 104 beds. Under construction. Architects, Fetherstonhaugh, Durnford, Bolton and Chadwick, Montreal.

L'Hôpital Saint-François d'Assise, Quebec City. 240 beds. Opened Dec., 1947. Architects, Caron and Blatter, Quebec City.

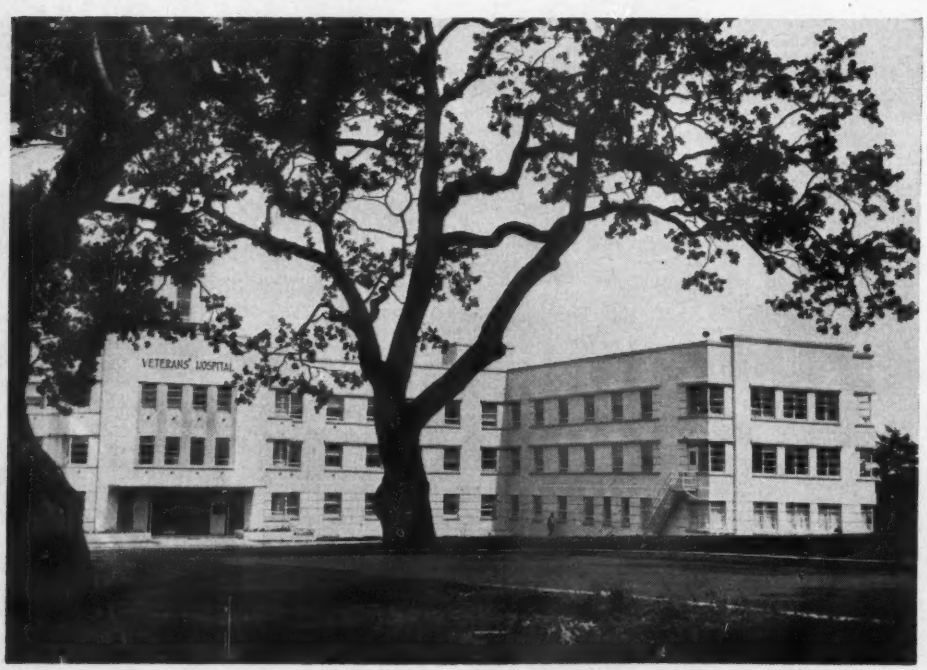
Victory Wing, Kingston General Hospital, Kingston, Ont. 125 beds. Completed 1948. Architects, Drever and Smith, Kingston; consultant architect, Harold J. Smith, Toronto.

General Hospital of Port Arthur, Port Arthur, Ont. New wing on left with 120 beds, 25 bassinets. Opened fall, 1948. Architect, Harold J. Smith, Toronto.

Sunnybrook Hospital (D.V.A.), Toronto. 1,450 beds. Officially opened, 1948. Architects, Allward and Gouinlock, Toronto.



Stratford General Hospital, Stratford, Ont. 168 beds and 16 bassinets. Under construction. Architects, Marani and Morris, Toronto.

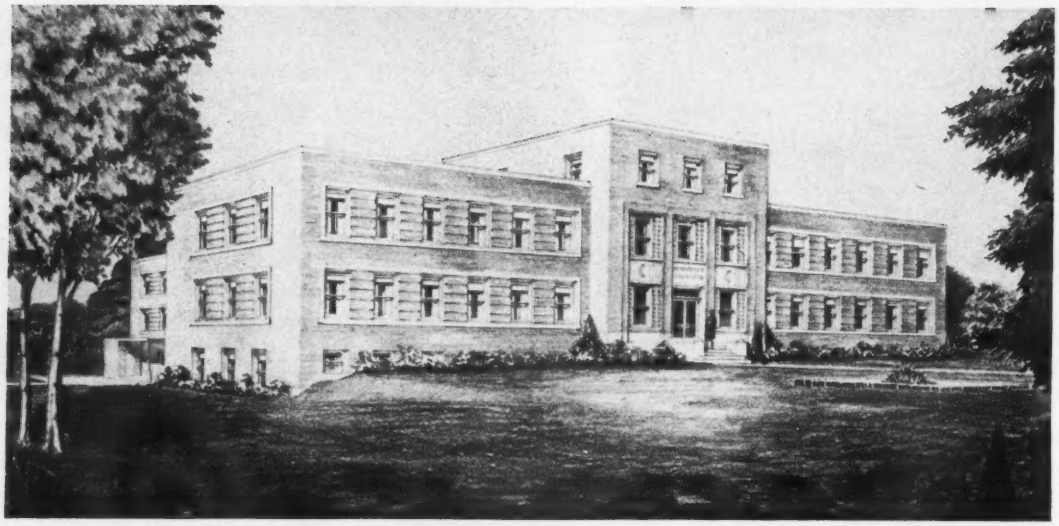


Victoria Veterans Hospital, Victoria. 250 beds. Opened 1947. Architects, Mercer and Mercer, Vancouver.

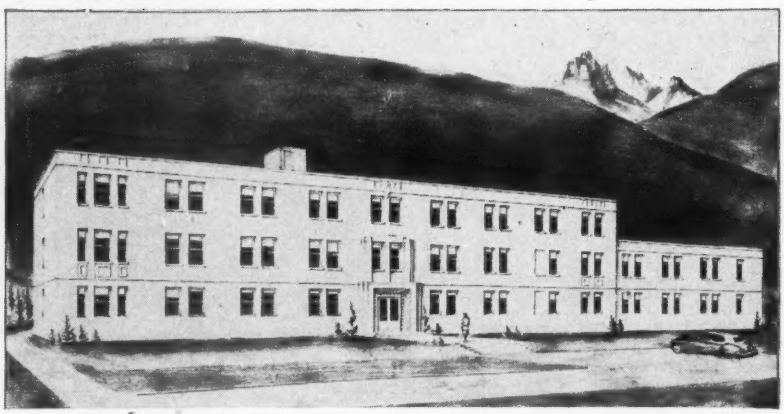
Princess Elizabeth Hospital, Winnipeg, unit for chronically ill, Winnipeg Municipal Hospitals. 208 beds. Under construction. Architects, Moody and Moore, Winnipeg.

Youville Hospital, Rouyn-Noranda, Que. 200 beds. Constructed in 1947. Architect, A. Martineau, Montreal.

Victoria General Hospital, Halifax. 400 beds. Opened 1948. Architect, Andrew R. Cobb; associate architect, Clifford St. John Wilson, Halifax.



Leamington District Memorial Hospital, Leamington, Ont. 51 beds and 18 bassinets. Under construction. Architect, Harold J. Smith, Toronto.



Crow's Nest Pass Municipal Hospital, Alberta. 60 beds. Completed last month. Architects, Meech, Mitchell and Meech, Lethbridge.

Hospital for Sick Children, Toronto. 600 beds. Under construction. Architects, Govan, Ferguson and Lindsay, Toronto.

Loyalty and Intelligent Co-operation on the Part of

HOSPITAL TRUSTEES

A "Sine Qua Non"

Rev. Sister Ignatius,
Antigonish, N.S.

THE survival of the voluntary hospital depends to no small extent upon the quality of its board of trustees, the qualifications of its administrator, and the relationship which exists between them. Someone has wisely compared this relationship to a wheel with its hub and spokes; the spokes representing the board of trustees with their diversified problems, and the hub, the administrator as the point of actual concentration.

Confidence in the Administrator

One of the most important responsibilities of the board of trustees is the selection of an energetic and efficient administrator who is a capable leader in the hospital field; a person of high ideals, broad vision, and an abundance of common sense. In hospitals operated by religious institutions, the appointment is made by the Council of the Congregation. Every administrator should have sufficient business knowledge to understand clearly the financial affairs of the hospital, should have the capacity to analyze problems, and above all should have those qualities which go to make up a pleasing personality. As she cannot attend to all details of management herself, she should be willing to delegate authority and responsibility to her subordinates and, in turn, those in charge of the various departments should be able, under her guidance, to manage efficiently that work with which they are entrusted.

Having vested in a trusted administrator full responsibility for the internal management of a hospital, board members should refrain from interfering with the details of that management. If the administrator is competent, the board should have utmost confidence in her judgment and she should respect that confidence by giving her best in service to the hospital.

It is regrettable that, in some cases, trustees do interfere with internal management—even to the extent of demanding the return of employees who have been dismissed for good reasons. It has been known, too, for trustees to interfere with the dismissal of student nurses who have been found to lack certain qualities necessary in those who are to assume the great responsibility of caring for the sick. A trustee, no matter how well-qualified he may be, must realize that he is not always a competent judge in these matters and that such action is not only unethical but far beneath the trust placed in a member of a hospital board.

Qualifications of the Trustee

What then should the administrator expect of the trustee? The answer is simply — plenty. First, he must be inspired with the spirit of Christian charity which, from the beginning, has been a dominant motive in the establishment of institutions for the care of the sick.

Rev. Sister Ignatius

Secondly, he must have a good reputation in the community for integrity of character. As it is desirable for the public to have confidence in those who direct the affairs of the institution, he must have some knowledge of and experience in business matters. It would be well to have at least one member of the board with a good knowledge of accounting who could understand thoroughly the financial standing of the institution and interpret it to the other members. By this is not meant a mere itemized account of receipts and expenditures but a true and complete picture of the whole plant with its assets and liabilities. Unfortunately, proper accounting seems to be a weak point in too many of our Maritime hospitals. It is extremely difficult to make administrators and trustees realize the importance of improving the accounting system in order that they may be in a position to give accurate and complete costs.

Thirdly, every trustee must be willing to give of his time and service in the interests of the hospital, contributing to its welfare without thought of personal reward. As a trustee of a public agency, it is unethical for him to derive personal gain from his trusteeship. If, as a businessman, he tries to win the patronage of the institution or seeks a job for a friend or dependent, he is placing himself in a very questionable position and is disqualifying himself for an important community service.

Duties

What duties does the administrator expect the trustee to perform in the smooth operation of the institution? Taken collectively, the board of trustees is responsible for the formulation of policies respecting administration but the execution of these policies must be left in the hands of the administrator.

In order to secure a high stand-

From an address presented at the annual meeting, Maritime Hospital Association, St. Andrews, N.B., 1948.

ard of medical service, it is the duty of the board to exercise due care and diligence in selecting the medical staff and to make such regulations as are necessary for the maintenance of these standards.

The hospital training school, being an integral part of the whole plant, is a department which demands the active interest of every hospital trustee. No matter how small the school is, through its very existence, the hospital owes to the community a responsibility for its proper management which cannot be minimized. This being so, no board of trustees should expect the administrator to assume the responsibility directly. To render efficient service, the administrator should undoubtedly have *control* of the entire hospital plant, but in strategic posts, she should be represented by capable and competent staff members, who are immediately responsible to her and answerable for the management or mismanagement of their posts.

The administrator expects the members of the board to familiarize themselves with the policies and procedures of other hospitals in order that they may bring to their own meetings constructive suggestions which would help them to carry out their duties more effectively.

The trustee is not expected to be a yes-man or a rubber stamp who merely sets the seal of his approval on all proceedings and policies without careful thought and consideration. There is a happy medium in trusteeship as well as in other lines of human endeavour.

Since the trustee must fulfill definite obligations, the administrator expects him to have an adequate knowledge of the nature of his trust. Hospital work represents a highly technical community service and so the more the trustee knows of its business and professional aspects, the more capably will he discharge his duties.

There are various magazines and pamphlets which provide excellent reading for those engaged in hospital work. The small magazine entitled *Trustee,* published each month by the American Hospital Association, should be in the hands of every board member and could be used profitably for discussion periods at meetings. Regional meetings and conferences, with attendant interchange of ideas and experiences, offer increased stimulus and information. No trustee will grow to his full capacity except through practical and concrete education.

Loyalty is a quality expected of every member of the hospital board. It gives the administrator a feeling of security and satisfaction to realize that each trustee is standing solidly behind her. There exist in a hospital many concrete problems which seem abstract to the layman. Any criticism of the institution and its policies should be brought to the attention of the administrator so that the causes of this criticism may be either explained or corrected.

The administrator expects of the board, constructive criticism from time to time. No institution and no administration is perfect; each has its weaknesses. If the administrator is wise, she will accept with gratitude the constructive criticism of the trustees and of other friends. If she has the confidence of the board, the capable administrator should be allowed considerable latitude. Even though she might make an occasional mistake, the board should be convinced that she is trying to do her best. The person who never errs, never accomplishes much in life.

Publicity

The board of trustees should act as an efficient publicity agent on behalf of the hospital. The public should be kept informed of the aims, activities, and needs of the hospital; indeed, the public should know a great deal more of the services it renders through various channels. To this end, it would be advisable to have a public relations committee selected from members of the board and other interested individuals who, in co-operation with the administrator, would act in this capacity.

Supplementary Study

The board should be willing and anxious to release the administrator periodically to take short courses in hospital administration at the expense of the institution. In 1947, the Maritime Hospital Association sponsored, for the benefit of administrators, an institute which was highly appreciated by those who were able to attend it. A similar institute will be held this year and it is hoped that even a larger number will be present. In permitting the administrator to attend such institutes and refresher courses, the hospital will gain more than can be accurately estimated. It is the administrator who, day after day, hour after hour, is in intimate contact with all the affairs of the hospital and whose every act must be based upon comprehensive knowledge and sound judgment. She should not be so over-burdened with work that she cannot find time for the constructive thinking and formulation of plans so necessary for the progressive development of the institution.

Co-operation

There should be a friendly, co-operative spirit between the board of trustees and the administrator. Both should keep before them the ultimate end of their united endeavours—the welfare of the sick and suffering. The fidelity with which the board adheres to its proper function of directing policies and of delegating their execution to the administrator, and the care and diligence with which the administrator executes them, will be the measure of the success and progress of the hospital.

Finally, we are living in a very unsettled world, spiritually, socially, and economically, and the hospital field has not remained immune to our troubled times. It is only through the united efforts of those who are interested that we can solve the many difficulties confronting us. May I repeat the words of a clergyman in one of his first prayers before the United States Senate last year: "Let us not be frightened by the problems that confront us, but rather, give Thee thanks that Thou hast matched us for this hour. May we resolve, God helping us, to be part of the answer and not part of the problem."

Budget Planning

Correlation of Anticipated Income and Service Volume

Arthur H. Hibson,
New York, N.Y.

IN the broad sense, a budget is a planned schedule of events for a specific period. If we analyse the various words used in this definition, we can interpret "plan" to mean past performance amended to reflect changes which are expected to occur in the future. We can interpret "schedule" to mean an orderly complete pattern, "events" to mean a definite set of happenings or transactions, and "specific period" to mean actual dates, not merely length of time.

Practically anything can be budgeted; but what we usually mean by a budget is a financial plan of operation which integrates income and expense, and which follows the detailed pattern of our accounting. Generally we use a budget for over-all planning of operations and for the management level of control. In our over-all planning, we use our budget on the policy level to relate income and expense so that the desired profit or deficit can be anticipated. We use it to set our rate policy so that we may determine with some degree of accuracy the relationship of income from our various grades of service. We use it to set our allowance policy with which we integrate free work with supplementary income. We use it to express our standards and our scope of service. Particularly in these days, nothing is the same this year as it was last year. Therefore, we continually face the necessity of remaking our policies to fit what we anticipate will happen during the current year.

On the administrative level, we use a budget to integrate departmental expenditures. Given a certain over-all possible expenditure, we budget the expense of each department, weighing its relative needs to the whole program of hospital operation. We measure whether we will carry out a program of statistical control in the accounting department, as opposed to a program of additional painting in the maintenance department.

From an address presented at the Western Canada Institute for Hospital Administrators and Trustees, Vancouver, October, 1948.

Purpose

Never does a hospital have sufficient funds available for everything which it desires to accomplish. In order to evaluate relative necessities, we must bring all our programs together at one time. This summarizing of future activities is accomplished in the financial budget and must take place before the beginning of the fiscal year.

We must integrate service and income, anticipating the patient-day volume and the use of adjunct services for patient-day or per patient.

Each department head lays out plans for the future year and, if these are approved during the development of the budget as a whole, is given authority to carry out those plans. The budget provides for month-to-month control of expenses, facilitates adjustments to current experience, and places responsibility clearly on the department head. His blanket authority to use specified funds compensates for his responsibility in the control of expenditures. One of the biggest advantages of a budget is that it forces a department head to draw up an annual plan of operation.

The budget has the faculty of showing both the expenditures and the income for a certain volume of operation in detail. It therefore gives a quick understanding of the effect on the deficit of variations from the anticipated volume of service. In the control of income, it highlights the changes from planned operation, makes possible rapid interpretation of the effect of the changes, and thereby stimulates action.

It must be remembered that a budget can be no more efficient than the regular accounting of the hospital. If accounting does not follow closely the functional pattern of the hospital, it is futile for the budget to be so designed, since the guidance provided by the budget can only be used where there is the opportunity to compare the budget to the actual performance.

Preparation

In the preparation of the budget, the first problem to be met is estimating the amount of service the hospital will provide in the planned year. In making this estimation it is necessary to consider: (a) what changes may occur which are beyond our control; (b) what changes will occur which are within our control; and (c) how these changes will affect the service volume of routine care and adjunct care. These general factors should be thought out by a committee familiar with the various aspects of the problem and, using their conclusions, a detailed budget of the service volume anticipated should be prepared.

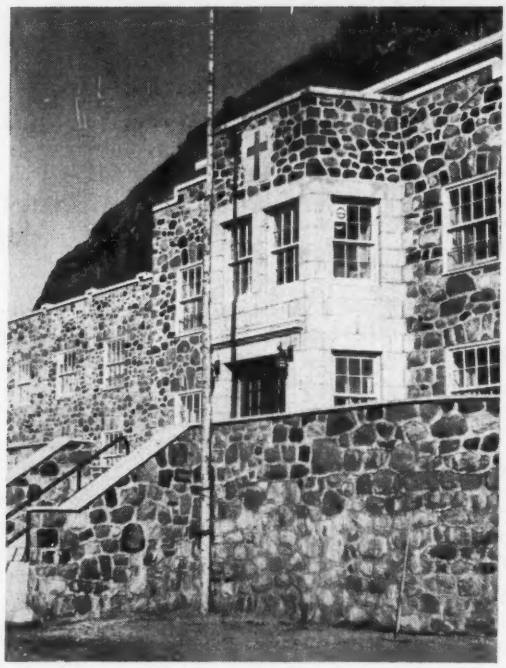
The second step is the preparation of the expense budget. As a preliminary, general over-all policies must be determined, such as salary increases and probable price levels for supplies and services. These general guides, together with the anticipated service volume, form the basis of judgment for the individual department head as to what differences can be expected from the actual experience of the previous year.

Each departmental budget should be formulated in two parts: (1) the budget necessary to carry the anticipated volume at the existing standards of service; and (2) the changes in standards and procedures recommended by the department head for the coming year. Both of these programs should be presented in terms of statistics

(Continued on page 90)

Foyer Dieppe

Rehabilitation Centre for Epileptics



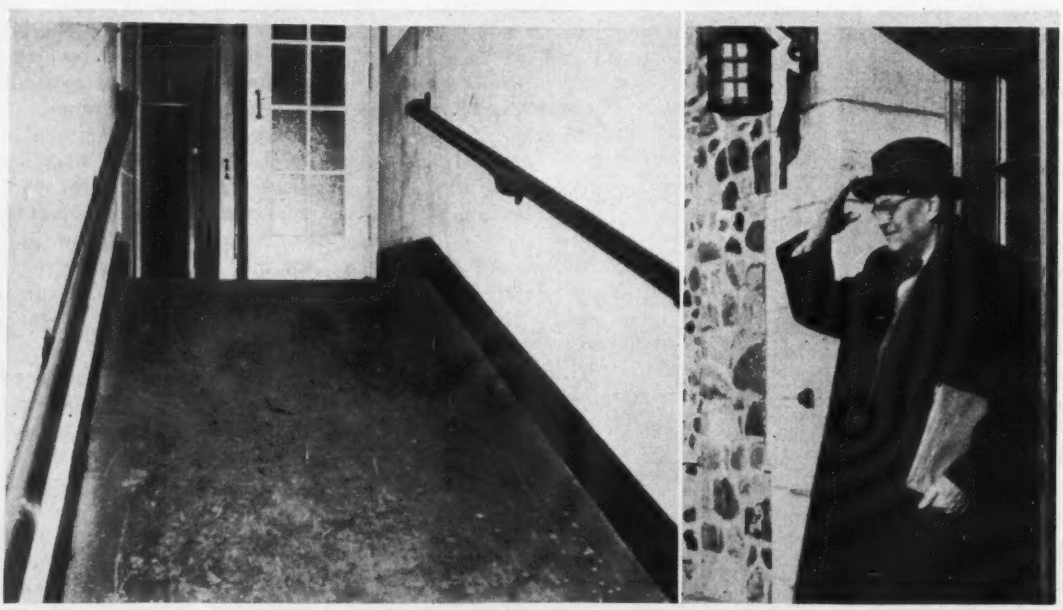
The Entrance to Dieppe House.

AT the foot of St. Hilaire Mountain, in a picturesque setting near Montreal, stands Dieppe House—a living war memorial to Canadian soldiers who lost their lives at Dieppe in 1942. It is not regarded as a hospital or an institution, but rather as a *home* established for the purpose of helping epileptics to lead a useful and satisfying life. Here, in an atmosphere of quiet consideration and freedom, patients are taught and encouraged to help themselves and others. Good food, exercise, fresh air and sunshine, help to build up their physical vitality and the knowledge that they are not "different", that they *can* do useful productive work, aids greatly in overcoming their nervousness in the presence of others and in restoring their self-confidence.

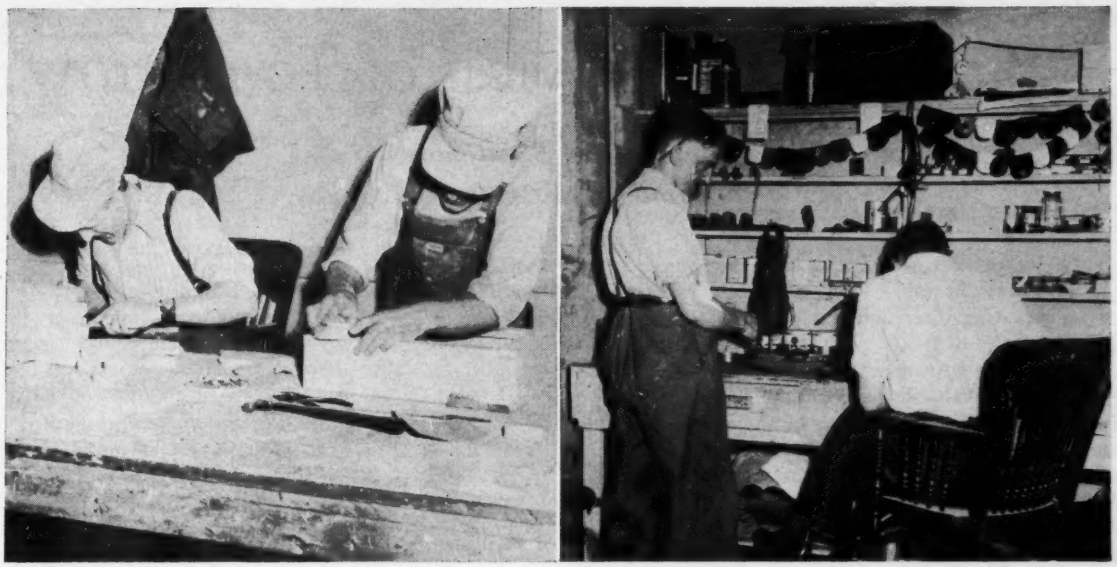
Dieppe House now has fifty-four patients, and accommodation for fifty more. These patients come from every walk of life. There are no restrictions as to nationality, colour or religion, although only males fifteen years or older from the province of Quebec are admitted, and no patient whose mentality is too greatly impaired is accepted.

A special feature of Dieppe House is the absence of doors and the use of ramps which replace stairs as a means of safeguarding the patients from injury. Bedrooms, each with three beds, have ventilators as well as two large windows to a room. Drapery replaces doors both on the door casing and on the wardrobes.

There is no difficult set of regulations for the patients and they are allowed a considerable degree of freedom. On arrival they spend a few days "getting acquainted", wandering about the spacious grounds, meeting the other patients, or relaxing in the large comfortable sitting-room. Pati-



To guard against injury by falling, ramps like the one shown above replace stairs. At right is George A. Savoy, president of Dieppe House.



Above, left, is shown a patient making toys and another working on a medicine cabinet in the carpentry shop. In the leather shop, right, patients busy themselves making small purses, belts, et cetera, and repairing shoes.

ents are given as much leeway as possible in the choice of work. Some prefer outdoor work and for these there is a farm with cattle and poultry. Crops consist of grains used for feeding the stock, as well as vegetables and fruits; of the latter enough is reserved for domestic use and the surplus sold, part of the returns being paid to the patients.

Those engaged in leather work, carpentry, cleaning, et cetera, are also compensated. At present a new workshop separated from the main building is being planned, and some of the men are engaged in making cement blocks for this purpose. The remuneration they receive is not intended to support them, but rather to serve as spending money, and to act as an incentive toward greater effort and better work.

Patients are not in any way confined. They are allowed to go about freely and to visit neighbouring towns or cities; the only provision is that two or more go at the same time in order to assist each other should it be necessary. They are placed "on their honour" to return by a certain time, and no difficulty is experienced in this regard.

Since the need for nursing care and for doctors' services is not great, the professional staff is small, comprised of one doctor, two nurses specially trained in the care of epileptics, and a dietitian. The cost per patient day is two to three dollars. This low figure is, to a large extent, due to the fact that most of the maintenance is looked after by patients under supervision, and that a great deal of food is supplied from the home-grown produce.

Such drugs are given as are prescribed by the physician recommending a patient to the institution, mainly dilantin, phenobarbital, et cetera. While these are important in controlling seizures, the quiet, friendly atmosphere and the sense of usefulness and independence developed in the patient play a major part.

Mr. Geo. A. Savoy, president of Dieppe House, cites examples of the success achieved by the methods used. Patients who have been experiencing from one to three seizures a day or a week at home go for long periods without one, or have none at all. A number of them, after a year or more without seizures, have been allowed to go home and to carry on with some type of work—often that which they have been taught at the House.

Palsy Victims to Have Permanent Centre at Woodeden

In the Komoka district, not far from London, Ont., is located the Woodeden Hospital Training School. Each summer, since its opening in 1946, the school has operated as a three-week camp for about 160 children. While all of these children are suffering from various crippling diseases, about half of them have been victims of cerebral palsy.

Present plans call for establishing Woodeden as a year-round centre exclusively for the treatment of children with cerebral palsy. Federal funds will be used to train two physiotherapists, an occupational therapist, a nurse, and a social worker; the medical director of the centre will be Dr. T. H. Coffey, professor of physical medicine at the University of Western Ontario.

There is much that can be done for these children, particularly in speech correction, physiotherapy and occupational therapy, academic and vocational training, and social adjustment.

C.S.L.T. Meets in May

The thirteenth annual convention of the Canadian Society of Laboratory Technologists will take place at the Chateau Laurier in Ottawa, on May 20th and 21st. An invitation is extended to all who are interested in attending. For further information, please write (Miss) Isabelle Mailhiot, 271 Besserer St., Ottawa.

Hospital Nursing Services of To-morrow

Trends that Seem Significant — and a Little Crystal-Gazing

Harvey Agnew, M.D.

IN these days of rapid social and economic transition and experimentation it is both risky and presumptuous to attempt to outline too specifically what will be the form and scope of hospital nursing service in the years to come. In this situation there are too many "ifs" and "whereas's" to be very specific. Much will depend, too, upon whether the swing of the pendulum to the left in recent years will continue and, if so, how far, or whether it has reached its maximum and will soon swing back to the other side.

There are, however, some trends that are clearly defined and others that seem to be taking shape. I would like to touch upon some of them.

In the first place we cannot expect to continue indefinitely under the conditions of today. Certainly, we are waging a losing battle in our attempts to maintain the *status quo* in nursing service and in nurse education. Why do I say this? Despite a greater enrolment in Canadian schools for nurses than ever before (over 12,000), our 170 schools of nursing cannot possibly meet the ever-increasing demands for nurses from hospitals, industry, and public health, especially in view of the heavy casualties at the altar. With our present program of hospital expansion, with greatly enlarged public health activities, and with more nurses than ever being absorbed into industry in hosts of new positions, the situation for all these fields (but particularly for hospitals with their night shifts and, often, isolated location) will become more difficult, and even more desperate, as the years go by. With higher ratios of hospitalization per population, a higher percentage of acutely ill patients because of the rapid turnover, more nursing hours per patient, and more clinical and nursing procedures per patient, something must be done about it—and without delay.

Nursing Services

Let us first consider nursing services. How can we make the inadequate supply equal the demand? The obvious first step is to re-assess and re-allocate nursing care duties. On this there is widespread agreement.

The whole gamut of clinical duties performed in our hospitals, from those of visiting and resident doctors to those of the wards, must be analyzed. Samples already done here and there are startling. As you know, some studies reveal 50 to 60 per cent of the time spent by graduate nurses is on work which could be done quite satisfactorily by others less well trained. Dr. Keslikowski told us at the recent American Hospital Association meeting in Atlantic City that 70 per cent could be done by others. We must re-assess the duties and responsibilities of each group. This alone would go a long way to correct the situation.

Moreover, this re-assessment of duties and more effective utilization of hours on duty could be applied with equal force to the work of nurses in industry, in public health, and in doctors' offices.

Practical Nurses

In this connection, we think at once of the trained practical nurses (or nursing assistants). Dr. George S. Young, then president of the Ontario Medical Association, advocated this development twenty-four years ago. Manitoba deserves much credit for being the first province in Canada to set up properly organized schools for practical nurses and to put through a licensing act. This instructed group is fast supplanting the former untrained or haphazardly trained ward aides and would seem to be here to stay.

The question is, Can we train sufficient practical nurses to meet future demands? I have some reservations in that regard unless we can raise their status. The courses are not as well patronized as one would like.

In hospital work we find that our graduate nurses—registered nurses—are divided into two groups: those who might be termed "general practitioners" and those who have done varying degrees of post-graduate work and are qualified for supervision, instruction, administration, or other specific fields. Also, we have practical nurses (or nursing assistants) with 9 to 12 months of training. These are supplemented by ward aides—usually trained in varying fashion on the job—ward secretaries, technicians, and others.

Year by year the level of undergraduate training is rising and more of our graduate nurses are taking post-graduate work. With the new federal grants for personnel training this tendency should increase. With the growing complexity of medical care, we can expect more specialized tasks to be assumed by the nurses and, as a corollary, more of the less exacting duties will be turned over to the practical nurses. An article a year ago in *The American Journal of Nursing* listed eighteen nursing procedures which formerly were performed solely by physicians (anaesthetics, intra-muscular injections, et cetera).

The Brown Report

A new book which will arouse much discussion is the report on *Nursing for the Future*, by Esther Lucile Brown, Ph.D., Director of Studies in the Professions, the Russell Sage Foundation. After analyzing educational methods in social work, engineering, medicine, and law, she now turns the eye of a trained and outside observer on nursing. She finds much that is good and much that is wrong. She believes that, although nurses are dissatisfied, they do not dislike bedside nursing—only

From an address at the Convention of the Manitoba Hospital Association in Winnipeg, October, 1948.

the conditions under which it is often practised (p. 54). She has a passing good word for the practical nurse but notes the objections of those nurse leaders who want nothing but the best in nursing service for their patients (p. 61).

This book is essentially a demand for higher standards in nurse education. The author would close several hundreds of schools in the United States and favours the large urban school. She is particularly partial to university schools with their broad basis of education. Emphasis is laid on a better training in psychology and in the psychosomatic aspects of nursing care—a very sound recommendation. But if I have a criticism of this thoughtful work, it is that the book does not indicate to me how nursing of the future is really going to cover the nursing needs of the average patient in the average small hospital. I would like to have seen Dr. Brown give more thought to the serious nursing problems of the small centre. As a matter of repeated observation, few writers — perhaps because their setting and thinking are urban—give sufficient thought to rural nursing.*

Is This Heresy?

Let us presume that Dr. Brown is feeling the pulse of nurse leadership and that more and more of our nurse training will be done in centres connected with university facilities. In summing up the advantages which such training gives, we cannot overlook the likely tendency for it to become more increasingly difficult for hospitals in general, particularly those away from the teaching centres, to maintain their ordinary bedside nursing care.

Even apart from this development, as the tendency in the training of all kinds of students is to develop the courses steadily to more advanced levels, one anticipates that, in the years to come, we may find it desirable to give the so-called "practical nurse" more and more training until she is able to do, not 50 to 60 per cent of present day general duty nurse tasks, but perhaps 85 to 90 per cent. You shake your head, but remember how the training of nurses has changed in the past 25 years. In turn, looking into the future, we would expect the graduate nurse to become better trained in special tasks and become busy doing work commensurate with her training and, therefore, much more to her liking. We would anticipate that this changed status would have reflections in her pay cheque, too.

This development may be a logical solution to the debatable but reasonable suggestion raised in nursing circles a few years ago that there be two levels of nurse training—one, say, of two years for specialized responsibilities. The Windsor experiment may or may not prove the two-year course to be financially feasible but, in my opinion, some such division of training into a course of less than three years and into one of over three years is inevitable. This end result of two standards of qualifications may come by another route than that usually discussed—by elevating the standards for *both* practical and registered nurses, rather than by having two grades of the latter.†

In that case we would find that the practical nurse would have a better status than she has now. This would encourage recruitment, now none too good, and would fill the need of so many of the sick public who view with dismay the tendency of the nursing profession to forsake the

(Continued on page 100)

**See review of Dr. Brown's book, "The Canadian Hospital", December, 1948, p. 42.*

†We have since noted in the Report of the Committee on the Function of Nursing (U.S.A.) published in November by the MacMillan Company as "A Program for the Nursing Profession" that the Committee is "recommending a division in the nursing function, with the bulk of the nursing done by the practical nurses. . . The two groups would work together as members of a nurse team, supervised by the professional nurse."

National Nursing Survey to be Postponed

WORD has been received from the Department of National Health and Welfare, Ottawa, that action has been deferred in undertaking the national survey of nursing which was strongly recommended by the Joint Committee on Nursing of the Canadian Nurses' Association, the Canadian Hospital Council, the Canadian Medical Association, and the Department of National Health and Welfare. It is now proposed to wait until the provincial health survey committees will have reported "in some more or less final degree in respect to their local surveys of the nursing situation".

This deferment has been made, presumably, to take advantage of any fact-finding surveys being done by the provincial committees and thus avoid duplication of expense and effort. It is hoped that this action will not make it still more difficult to achieve a national solution. Different opinions seem to prevail as to the extent to which provincial committees should delve into the broad problems of providing various levels of nursing service in the hospital, the home, industry, et cetera, and of appraising and developing educational techniques and facilities. It is doubtful if any provincial committee will be able to go into the subject as thoroughly as the serious situation demands.

Without a co-ordinated basis of study, it is likely that nine different approaches of varying degrees of thoroughness will be made, with the probability that much of the detail will need to be done over again when the national study is undertaken.

Following the November conference at Ottawa it was arranged that one of the provinces, Alberta, should propose that the necessary funds be taken from the research grant which had been set up mainly for sociological and administrative research. (See *Canadian Hospital,* Jan., p. 34). This fund has not been divided, as in the case of the other grants, but can be utilized by having a province propose a project and then having the project approved by the other provinces through the Dominion Council of Health. This step was taken by Alberta in due course, the decision to defer any action being made later.

Red Cross Transfusion Plan Meeting Strong Opposition

THE Red Cross plan for taking over the collecting and provision of all blood for transfusions in civilian hospitals has met severe criticism in several Ontario and Quebec cities in recent weeks. Most serious opposition has arisen in Toronto where the Toronto Hospital Council and the Academy of Medicine have come out in definite opposition to the plan as developed by the Red Cross. In Montreal, some of the larger hospitals have indicated that they do not propose to give up their highly efficient blood banks until certain that the Red Cross arrangement will provide their patients with equally good service. A similar attitude is being taken in Hamilton.

There has not been, and would not now seem to be, criticism of the basic idea that the Red Cross assist in the collection and furnishing of blood; its value, particularly in rural areas, must be obvious to all. Nevertheless, in view of the fact that so many of the larger hospitals now have smoothly operating and quite satisfactory blood banks, there is a general opinion in these areas that the efforts of the Red Cross should be directed towards furnishing blood to the smaller hospitals without blood banks and, perhaps, helping to make blood available to the poor in larger centres. Under the contract arrangements drawn up by the Canadian Red Cross Society, the hospitals must agree to use no other blood than that supplied by the Red Cross. The hospitals which have built up fine blood banks over the years and, in some cases, use them as depots for other smaller hospitals, are loathe to abandon those arrangements, which it has taken so long to establish, in favour of a plan which may or may not be as successful. They see no reason why the Red Cross should not work with them rather than insist upon creating a monopoly.

Objection is being taken, also, to the contract which the hospital must sign. This objection was voiced at the Alberta meeting in November and at the O.H.A. Board of Directors' meeting in January. Certain clauses, such as the condition that no other blood be used and that there be no service charge, despite obvious continuing items of cost to the hospital, are still in the contract on the insistence of the Red Cross. Hospitals with excellent blood services are objecting to being shown and asked to sign, on short notice, standard contracts which to them seem unfair and concerning the details of which they have not been previously consulted. Pathologists resent the insistence of the Red Cross upon inspecting hospital laboratories and the work of distinguished laboratory directors.

However, certain legal points to which the Canadian Hospital Council solicitor took exception last autumn have been straightened out. (See January issue, C.H. Jl., page 26.) These clauses, as now worded, are designed to place blame for any untoward results more fairly upon whatever party, if any, is found responsible, rather than largely upon the hospital.

(To clarify the January editorial, the Canadian Hospital Council has not approved the contract as a whole. The President, Secretary, and Solicitor, did go over with Red Cross representatives those clauses in the contract as it had been already negotiated with various hospitals in the west, and which seemed unfair to the hospitals from the viewpoint of legal responsibility. The re-wording agreed upon seemed to us to be fair to both parties. The discussions did not cover the two points at issue mentioned above, clauses 7 and 15).

It has been unfortunate that the publicity approach in some of these cities has been undiplomatic, to say the least. Press and radio publicity for donors has been launched before clearing with the hospitals. In Hamilton and other Ontario centres getting Toronto papers, the hospitals' first intimation came through the press. This publicity was badly phrased to win metropolitan hospital support, for it stressed the inability of hospitals to provide adequate blood service (not confining this sweeping statement to smaller hospitals without blood banks) and implied that hospitals were making large profits out of their blood banks.

This very unfortunate situation might easily have been averted if: (a) there had been a little more realization that urban hospitals and their staffs had already worked out a thoroughly satisfactory blood service for everybody, rich or poor; (b) a joint plan had been worked out with hospitals now operating banks, rather than an insistence upon a monopoly; (c) it had not been repeatedly stated that hospitals would have *no* expense under the Red Cross plan; (d) a more diplomatic approach to the hospital administrators, pathologists and the profession had been made; and (e) there had been a less irresponsible publicity policy, which was making its points to the detriment of others.

Statement of the Toronto Hospital Council

Publicity already released by the Canadian Red Cross Society would lead the public to believe that the hospitals have been operating blood banks at a profit. This statement is obviously incorrect as all banks contacted state that they barely balance revenue and expense.

The Toronto Hospital Council takes exception to the statement by Red Cross officials that the hospitals have a profit motive in view in providing blood bank facilities. In most general hospitals of the Toronto area revenues earned from operation of blood banks do not meet expenses incurred to maintain a continuous twenty-four hour transfusion service. Despite centralization of transfusion services under control of the Canadian Red Cross Society, the hospitals will be obligated to continue to maintain certain equipment and personnel for the handling and administration of blood made available by the Society.

This Council knows of no instance of a patient in a Toronto hospital, during the past eight years, who has ever suffered through lack of blood transfusions, whether able to pay for such service or not. The hospitals of this city have furnished all blood required by the physicians of Toronto for treatment of their patients to the full extent of their individual needs. Under present procedures of most general hospitals there is no charge made for blood used in transfusions if the blood used is replaced.

The Toronto Hospital Council is in full sympathy with the aims of the Canadian Red Cross Society in extending full blood transfusion service to the indigent ill and areas where such ser-

vice is presently not available. The Toronto Hospital Council disagrees that all existing blood banks in the general hospitals of the city, which have been built up to successful operating units over a period of many years, should now be abolished in favour of one central organization.

It is our belief that the present aims of the Canadian Red Cross Society could be as well achieved through support of existing bank facilities in the large city hospitals and the extension by Red Cross of such service to the smaller rural units. While centralization of certain services is desirable, present trends would indicate that the vital public services are more satisfactory on a decentralized system, particularly in times of national disaster. In most general hospitals, highly trained technical personnel is presently made available to provide blood transfusion service; discontinuance at hospital level and centralization in the hands of only the Red Cross Society would place the hospitals in a position of no longer having such personnel immediately available in their own hospitals for all emergencies.

To meet the cost of such personnel and equipment, the hospitals must have a source of income. Whereas the Red Cross Society has recourse to a national appeal for funds for support of its work, and the governments have power of taxation wherefrom to draw funds for their contributions, most hospitals have no other source of income than payments by their patients for services rendered. The hospitals are giving and will continue to give any blood transfusion service required, but funds must be available to pay the salaries of necessary personnel and for the purchase of necessary equipment which are still the responsibility of the hospital under the proposed plan of the Canadian Red Cross Society.

Statement of the Toronto Academy of Medicine

The Academy approves of the principle of blood banks. That these banks should be operated by the Red Cross Society, a purely voluntary agency, is debatable.

The Academy strongly objects to a number of implications and statements attributable to responsible officials of the Red Cross Society and carried in the public press and over the radio.

1. The implication that blood has not been available in Toronto and that hundreds have been dying for want of this blood is untrue. In fact more than ten thousand transfusions of blood were given to patients in Toronto hospitals under the care of Toronto doctors during 1948. Many excellent blood banks are in operation in this city, the first in Canada having been started here nearly twelve years ago. All of this was accomplished without any assistance whatever from the Red Cross Society or governments. In fact members of this Academy have provided much of the fundamental knowledge which makes the operation of blood banks possible.

2. The Academy doubts the statement that hospitals make money out of blood banks. The Red Cross Society maintains that the blood will be free, but, of course, this service will cost a great deal of money and this money will have to come from public contributions. In Toronto hospitals today no patients is denied blood on account of expense.

3. The Academy disapproves of the requirement of the Red Cross Society of inspecting the hospital laboratories operated by distinguished members of the profession and of examining the work and procedures of these men.

It is felt by the Academy that the whole proposal for the blood bank should be carefully reviewed by a competent committee representative of all parties concerned including the medical profession. Further, the Academy feels that the responsible officers of the Red Cross Society should scrutinize and revise their publicity in the interests of accuracy. The Committee asks the press to give the public the facts about existing blood banks. The Academy urges the establishment of a blood transfusion service for areas not now properly served and the support of the existing services.

Statement of the Ontario Association of Pathologists

This Association approves in general the Red Cross Blood Transfusion service program, providing the policy of this program is in essential agreement with that laid down by the American Red Cross Society with particular reference to the following:

"The organization and development of the Red Cross Blood bank program in a community should be contingent upon a request for this service from the medical group and/or the hospital or hospital group of that community."

Furthermore, this Association strongly approves the following principles:

"If a hospital participating in the Red Cross Blood Bank plan is required to provide space, personnel and equipment, or assume any responsibility for the technique of the procedure of giving blood or blood products that hospital should be allowed to make an appropriate service charge . . . ."•

As We Go to Press

On Sunday, January 30, some thirty representatives of the Ontario Hospital Association, Ontario Association of Pathologists, Toronto Academy of Medicine, College of Physicians and Surgeons of Ontario, Ontario Medical Association, Toronto Hospital Council, and the Canadian Red Cross Society, met to work out a basis of contract acceptable to all parties. All hospital and medical groups represented, although approving the general proposal in principle, presented reasons for their opposition to various aspects of the plan, including publicity methods.

An alternate plan was proposed whereby the Red Cross would work *with* existing blood banks rather than replace them, serving those hospitals in rural areas and elsewhere now without blood banks, and supplementing the blood bank facilities of larger hospitals to aid those who cannot pay and cannot provide replacing blood, no service charge to be made for Red Cross blood. This proposal was generally approved by the medical and hospital representatives present. It will be presented by Col. Arthur Bishop, national chairman of the Canadian Red Cross Society, to that body for consideration.

Information received would indicate that the larger hospitals in Montreal are not prepared to discontinue their blood banks under a contract which would require them to use no other blood than Red Cross blood and not to lend blood to other hospitals.

Margarine Sale Jeopardized

Hospital boards, hoping to enlist the use of margarine in curbing the rising cost of hospitalization, may find this means blocked if pressure now being made in government circles is successful. Commercial interests and groups, striving to prevent the use of this food product, have been making every effort to have it become mandatory that margarine be sold in such a form that it would either look like lard or have a colour that would not appeal to the consumer. If margarine is a wholesome food—and all scientific evidence shows that it is — no mercenary interests should be permitted to deny this product to the public.

One Hundred Years of Medical Progress

A Century of Notable Achievement

Earle P. Scarlett,
M.D., F.R.C.P., (C), F.A.C.P.
Calgary, Alta.

PART I

This year, the Royal Canadian Institute of Toronto, the oldest existing scientific society in Canada, celebrates its hundredth anniversary. To commemorate the event, a special Centennial Volume has been issued in which ten outstanding authorities review the century's progress in ten broad fields of pure and applied science. Dr. Scarlett, one of the best informed and most gifted writers in Canada, was invited to contribute the chapter on medicine. We are indebted to the Royal Canadian Institute and to Dr. Scarlett for permission to publish this highly informative chapter in this, and the March, issue.

IN the century that has elapsed since the founding of the Royal Canadian Institute, man has travelled far, and the record of his pilgrimage is bewildering in its complexity and challenging in its extent. No period since the Renaissance has seen such cosmic drama, upheaval of thought, or social change. Within this short span, the entire face of the world and the character of human thought and belief have been wholly transformed.

No field of human thought and activity better exhibits this revolutionary change of outlook, this increasing tempo, and this creative genius than medicine. The history of medicine, of course, is in large part the history of life and civilization. It embraces all the sciences, and yet remains an art. It unites tradition and invention and, while adopting the jargon of modern science, it continues with its ancient humanistic piety to address life and its ailments in polite, if not always accurate, Latin and Greek. Despite its shortcomings, medicine stands today as one of the great triumphs of the human spirit. Through the past century of turmoil and war, it has continued to apply knowledge to the relief of suffering and the prevention of disease, and in that task has recognized no national boundaries and known no enmities. As a result, we have seen the ironical paradox that at a time when man has been scourged by war as never before, he has never been so safe against the threat of disease.

Subheads are our own.—Edit.

The Spark of Human History

Thus to the individual who looks at the record of human history with despair and is inclined to debate gloomily the question of progress, the advances of medicine offer hope and consolation. For the fact of progress is written plain and large on the pages of medical history. Here, in the logic of discovery, the development of ideas, and the application of knowledge to human needs, lies the vitalizing and redeeming spark of human history. This is not the expression of an easy optimism, for it is possible to take pride in the progress of medicine, and at the same time remain humble and chastened in the face of the virtues of the past and the follies of the present. Indeed, the recital of medical achievements may be in large part a grouping and listing of facts—and facts have no soul. But the best of the facts in medical science and practice may soon lie smouldering in the grave, while the spirit of medicine which has for the season embraced those facts goes marching on.

Dr. E. P. Scarlett

The story of medicine in the last hundred years is such a vast theme that within the compass of a single chapter it can be sketched only in the broadest terms. One can do little more than indicate, it is hoped with some sense of proportion, how medicine under the awakening impetus of natural science burst the bonds of dogma a century ago, expanded on a myriad of fronts, and rapidly reached its present stature. This same development has been reflected in Canadian medicine. It is a coincidence—and a happy one for the purpose of this history—that the renaissance of medicine coincides almost exactly with the life-span of the Royal Canadian Institute.

An Eventful Decade

The Royal Canadian Institute came into being in a decade that witnessed the birth of many scientific organizations destined to have a profound influence upon the world. Europe was in turmoil; there was profound social unrest; war as ever was on the horizon. Canada was emerging from an unfortunate rebellion; there were many sharp tensions within and without the country. At the same time, the world was becoming charged with expectancy, and every department of culture and science was quickened by the promise of revolutionary achievements.

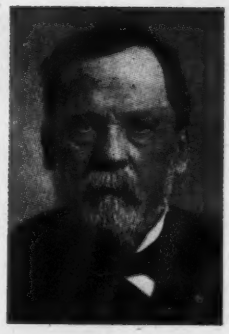
Medicine in 1840, with some notable exceptions, still lumbered along in the traditions and practices of the ancient medical systems of the Greeks, Romans, and Arabs. Thus, in 1839, Emile Littré

was publishing a translation of Hipprocates for the general practitioner. Medical practice was not much more than a practical art in which folklore and the beginnings of organized knowledge of disease were intermingled. The horse and buggy, saddle-bags, sulphur and molasses, and kitchen-table surgery were the order of the day. Quackery was rampant, medical training pitifully inadequate, and medical practitioners virtually helpless before the ravages of epidemic and endemic diseases. Of the 90,000 persons who in 1847 left Great Britain and Ireland for Canada, more than one-third caught ship-fever (typhus), and one in every seven died either on shipboard or after reaching Canada.

Then about the middle of the century, due to the awakening of interest in all branches of natural science, medicine suddenly came alive, and entered a period of rapid development, widening into a broad delta until today it is impossible for any single individual to compass all its tributaries or its many ramifications. Hence it is true to say that modern medicine dates back only a hundred years, and the swiftly ascending curve of its achievements parallels that of the fundamental sciences of biology, chemistry and physics.

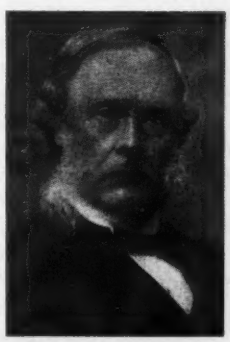
The initial impulse came from a group of far-reaching contributions within the short interval of two decades, all of which proved epoch-making. The first was the formulation of the cellular theory by Rudolf Virchow, the greatest of all Germany's medical thinkers, a concept on which rests the whole edifice of the modern study of disease. The second was the work of the Frenchman, Claude Bernard, the experimental physiologist, whose investigations on the liver, the mechanism of digestion, and the circulation laid the foundations of modern physiology. These two medical sciences, pathology and physiology, thus established, within the succeeding half century did (as Osler said) "more to emancipate medicine from routine and thraldom of authority than all the work of all the physicians from the days of Hippocrates to Jenner."

On the medical scene at the



Louis Pasteur

same time was the mighty figure of another Frenchman, Louis Pasteur, who by 1859 (the year of the publication of Darwin's *Origin of Species)* was deep in the study of the origin of life, and who established the doctrine of the germ theory of disease, thereby laying the foundations of the science of bacteriology. This science was firmly established by the work of the German, Robert Koch, who in 1882 demonstrated the organism of tuberculosis. The new knowledge was quickly applied to med-



Lord Lister

ical practice by Lord Lister, who first recorded his observations on the antiseptic system of surgery in 1867, and thus inaugurated modern surgery. Two other figures, the eccentric Viennese genius, Ignaz Semmelweiss, and the lovable Oliver Wendell Holmes, had in the meantime pointed out the infective nature of puerperal fever, and thus eventually revolutionized the practice of midwifery.

Anaesthesia

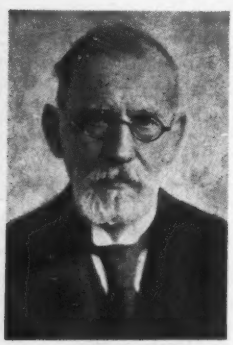
Rounding out these initial epochal discoveries was the introduction of anæsthesia, which for the most part was of American origin. The word anæsthesia itself was coined by Oliver Wendell Holmes. Two men, working quite independently of each other, in the early eighteen-forties, demonstrated the anæsthetic power of ether—Dr. Crawford W. Long, a Georgia physician, who first operated with ether anæsthesia in 1842, and a Boston dentist, Dr. William T. G. Morton, who gave the first public demonstration of the method at the Massachusetts General Hospital, Boston, in 1846. Another dentist, Dr. Horace Wells of Hartford, Conn., had previously applied nitrous oxide to purposes of dental anæsthesia. Then, in 1847, Sir James Young Simpson of Edinburgh discovered the anæsthetic properties of Chloroform and used it in obstetrical practice. Finally, John Snow of London, the first specialist in the field, laid in his experimental work the foundations of our modern scientific knowledge of anaesthesia. Local anæsthesia by cocaine was introduced in 1884 by a young Viennese ophthalmologist, Karl Koller.

Later Developments

Thus the dawn of the twentieth century found medicine firmly established on the scientific side upon physiological investigation, and advancing rapidly with new machines and tools. This increasing body of knowledge, derived from the special sciences, brought into being new divisions of medical knowledge and created separate departments, the so-called "specialties". Thereafter medicine expanded on so many fronts that it is possible to refer only briefly to some of the more notable advances. This is the period of scientific subdivision in medicine and it can only be outlined with the broadest strokes.

In clinical medicine, the torch lighted by the French school of Corvisart, Lænnec, and Louis, was borne to central Europe by Skoda, to the British Isles by Stokes, Graves, Bright, and Addison, and to America by Gerhard, Pepper, and Bowditch. Physiology continued to expand under the hands of Magendie, Müller, and Ludwig, and the studies of William Beaumont on this continent and Pavlov in Russia opened new avenues of thought and specula-

tion. Closely associated with applied physiology is the new science of biochemistry, which developed out of physiological chemistry, and which has made its greatest contribution in the field of nutrition, dealing with the deficiency diseases, such as scurvy, rickets, and beri-beri, and with the metabolic diseases, such as Addison's disease of the adrenal glands, thyroid gland disturbances, and diabetes. Allied to this work has been the recognition of accessory food factors or vitamins (the name was coined in 1911 by the Polish



Paul Ehrlich

physiologist, Funk) with which the name of the English chemist, Hopkins, and the American, McCollum, are linked.

The fruits of the bacteriological era have been reaped in the control of infectious diseases, one of the most far-reaching of modern achievements, in so far as the life of man on this planet is concerned. The scourges of the epidemic diseases of typhoid fever, diphtheria, smallpox, plague, cholera, typhus fever, and scarlet fever have been removed. This control of infectious disease has made possible the southward march of civilization into the tropics with the control of malaria, yellow fever, and African sleeping sickness. With regard to the infectious diseases, the ideal of medicine is prevention and, failing this, its aim is a specific form of treatment. In this way, the incidence and mortality of such diseases as tuberculosis, pneumonia, and syphilis, have been greatly reduced and brought under control. Progress in the knowledge and treatment of syphilis has been particularly encouraging as the result of the work of such men as Wassermann and Ehrlich.

Marie Curie

The extraordinary developments of surgery during the present century would require a whole treatise in themselves. The surgical specialties have developed in their own right—orthopædic surgery, genito-urinary surgery, eye, ear, nose, and throat surgery, and gynæcological surgery. Each field is crowded with brilliant names from every part of the world. Obstetrics has similarly developed, particularly in pre-natal care; and the intensive study made of the infant and normal child and of the diseases of childhood has brought into being the specialty of pædiatrics. The study of nervous diseases, neurology, has become a specialty in its own right, and its most important contribution has been the treatment of syphilis of the nervous system and the effective handling of brain tumours. The problem of mental disease has given rise to the specialty of psychiatry, which in a short period has revolutionized the handling of the insane and, following the pioneer work of Freud, has created new dimensions in the study of human behaviour.

Inestimable benefits to mankind have derived from the x-ray and radium, which were discovered in the nineties, and the application of which to the diagnosis and treatment of disease has steadily been developed in this century. They were the contributions of physicists, Wilhelm Roentgen, and Pierre and Marie Curie. In 1898 Walter B. Cannon of Boston visualized movements of the stomach in the x-ray after swallowing bismuth, and thus initiated the x-ray diagnosis of diseases of the gastro-intestinal tract.

The growth of the public health movement together with preventive medicine arose in the main from the work of two nineteenth-century reformers, disciples of the social philosopher Jeremy Bentham, Southwood Smith and Edwin Chadwick. The condition of hospitals has been transformed under the changes in surgery and medicine while the revolution in nursing care, associated with the name of Florence Nightingale, has altered the whole problem of the treatment of disease and has probably saved as many lives as a good many of the medical and surgical advances put together.

Recent Medical Discoveries

The more important recent medical discoveries may be indicated as follows:

Landsteiner's discovery of blood groups (1901) and subsequent blood transfusion developments.

Einthoven's invention of a string galvanometer (1903) which made possible the electrocardiogram and a new era in the field of heart disease.

Von Pirquet's demonstration of allergy (1905) which initiated a new medical specialty.

Banting's introduction of insulin in the treatment of diabetes (1922).

Minot and Murphy's application of Whipple's previous observations in the introduction of liver in the treatment of pernicious anæmia (1926).

Domagk's discovery of the sulphonamide treatment of bacterial infection (1935).

Fleming's and Florey's introduction of penicillin in the treatment of bacterial infection (1941), which opened a new field of antibiotic therapy. Together with the sulphonamides, the antibiotics have dramatically reduced the mortality from one of man's oldest enemies, pneumonia.

(To be concluded in March issue)

Victorian Repression

We speak of Victorian repression but may not a part of it have been the self-discipline of people who believed in something. People who believe in nothing have every incentive for putting both feet in the trough.—*Warwick Deeping.*

The Hobby Corner

9. "The Potters", Mount St. Mary

OPERATED by the Sisters of St. Ann, a pioneer Community of British Columbia (1858), Mount Saint Mary is situated on three of the lovely boulevards of Victoria. It is devoted chiefly to the care of chronics of the province, the registration at present being one hundred infirmary and fifty private patients.

With this type of service, it was deemed advisable to develop hobbies for both the patients and the personnel. The Sisters, whose entire time is devoted to these patients, require an avenue of relaxation and have turned to pottery making. They were fortunate in having a friend, a mother of two St. Joseph's Hospital graduates, to instruct them one afternoon each week for eight weeks. They then joined the Victoria Pottery Club and, considering the little time they have to give to their hobby, their success has been phenomenal. They have realized some small profits from their handicraft which they are saving with a view to purchasing a kiln of their own, thus making it easier to instruct the patients and to encourage good results.

Three of the Sisters of Mount St. Mary at work on their hobby.

Tropical fish collecting, bird training, album making, sock knitting, and chocheting, are among the other hobbies at Mount St. Mary.

Some of the patients are very capable, displaying creditable creative ability, and their enthusiasm stimulates other patients toward better efforts.

These hobbies play a definite part in the life of the patients at the Institution, giving interest and contentment to many with broken bodies whose mental acumen is as alert as it was in their more fortunate days.

A few examples of the potters' handicraft.

Sister M. Berthe Dorais, s.g.m.
Superintendent at St. Boniface

Sister M. Berthe Dorais, s.g.m., formerly of St. Boniface Hospital, St. Boniface, Man., who left Manitoba last fall to study at St. Peter's General Hospital, New Brunswick, N.J., has now been appointed superintendent of St. Boniface Hospital. She returned to Canada to assume her new duties on January 16th.

Anniversary, not Jubilee

Mr. William (Bill) Gray, O.H.A. Director from Chatham, Ont., makes this contribution to our special number:

Two old ladies were discussing Queen Victoria's Jubilee. "Why do they call it a 'jubilee' and not an 'anniversary'?" asked one. "Well, you see", explained the other, "it's an anniversary if your husband is living, but a jubilee if he's dead."

(Note: This is an "anniversary" issue, for the founder, Mr. Chas. A. Edwards, is very much alive and is responsible for our fine advertising pages).

Congratulations— from our Colleagues

Canadian Medical Association Journal

"It is with peculiar pleasure that we send you our greetings and congratulations on the occasion of the 25th Anniversary of the founding of *The Canadian Hospital*. If to fulfil a need is success, your Journal has achieved a triumph. Hospital problems and developments cannot be separated from the practice of medicine, and for dealing with them we look with confidence to your pages.

"Our Association extends its warmest good wishes for your long continued prosperity."

"H. E. Macdermott", M.D., *Editor.*

Canadian Nurse

"*The Canadian Nurse*, the official organ of the nurses of Canada, congratulates *The Canadian Hospital* on the occasion of its Silver Anniversary.

"These are epoch-making days in the history of medical care in Canada. The grants made by the Federal government have underlined the importance of complete co-operation between all members of hospital boards and staffs in meeting the challenges of present-day development and expansion in hospital facilities. The Canadian Hospital Council carries a large part of the responsibility for tying together the manifold projects and interpreting the opportunities to the men and women of the community who are administering the enlarging services. The role of *The Canadian Hospital* in this venture will continue to increase its stature as month succeeds month. Our heartiest good wishes for your continued success."

"Margaret E. Kerr," Reg.N., *Editor.*

Hospitals

"Congratulations to *The Canadian Hospital* on its twenty-fifth birthday. Through it you are doing the kind of job that stirs our admiration, and even our envy, on this side of the border. We envy you its freshness,, its thoroughness, and the accuracy of its editorial aim. Because of these strong characteristics, I know *The Canadian Hospital* will have many more happy birthdays."

"John M. Storm", *Editor.*

Modern Hospital

"It is always astonishing to find that so many years have whirled by since an event that is remembered as 'only yesterday'. However, when we remember what hospitals were like back there in 1924, the wonder is not that the years have passed so swiftly, but that so much could have been accomplished in so short a time!

"Congratulations on your anniversary—and very best wishes from all of us here at *The Modern Hospital* for another quarter century of fine service to our hospitals."

"Otho Ball", M.D., *President.*

Hospital Progress

"The editors of *Hospital Progress* are happy to be able to congratulate *The Canadian Hospital* on its twenty-fifth birthday. As a professional journal in the field of health, *The Canadian Hospital* is recognized for its constructive leadership and for its devotion to the ideals of good hospital care for the Canadian people. Best wishes for the continuation of this valuable work."

"John J. Flanagan, S.J., *for the Editors.*

Hospital Management

"Please accept my congratulations and best wishes for your continued success in serving the Canadian hospital field. I am sure that you will continue to do a fine job.

"Canadian hospitals have been well served through your journal, and under your distinguished editorship I know it will continue to reflect their interests and to serve their needs. With best wishes, I remain".

"G. D. Crain, Jr.", *Publisher.*

Conseil des Hôpitaux Catholiques du Canada

"Voilà vingt cinq ans que votre Revue est au service des Hôpitaux Canadiens. Ses nombreuses années de succès témoignent de sa réelle valeur. Malgré les multiples difficultés surtout financières qui ont accompagné votre naissance, vous vous êtes maintenu et vous avez persévéré avec le courage et l'opiniatreté qui caractérise le peuple canadien.

"Vous avez réussi à rendre votre Revue intéressante, pratique et utile, en publiant des articles qui ne s'adressent pas à un seul milieu, mais à tous les hôpitaux, les petits comme les grands. C'est là un fait important que met votre Revue à la portée de tous et qui permet à chacun d'en tirer grand avantage.

"Vos articles sont substantiels et prêtent admirablement à la réflexion, qui est un élément essentiel de la discussion, laquelle conduit nécessairement aux conclusions, point de départ du progrès.

"Vous avez eu aussi la courtoisie d'écrire plusieurs de vos articles en français, c'est un beau geste que l'élément français du pays apprécie à sa juste valeur.

"Le succès et la continuité de votre Journal ne peuvent faire de doute, puisqu'il possède toutes les qualités essentielles à une bonne revue.

"Aussi est-ce à juste titre que le Conseil des Hôpitaux Catholiques du Canada offre ses plus sincères félicitations à tous ceux qui depuis le début ont contribué au maintien, au progrès et au succès de votre Revue."

"Hector L. Bertrand, S.J.", *président.*

* * * *

"Twenty-five years of service is an impressive record for any magazine but, when one considers the beginnings of *The Canadian Hospital*, the many difficulties, financial and otherwise, encountered and overcome before it be-

came the official journal of the Canadian Hospital Council of Canada, one cannot help but admire and congratulate all those who, for the past twenty-five years, have devoted a great part of their lives and energies to the progress of this magazine.

"*The Canadian Hospital* is practical. It is of help to all types of hospitals. Its articles are informative and up-to-date, sufficiently so to please the largest and most progressive hospitals but, at the same time, its editors do not overlook the necessity for articles that will be of interest to and satisfy the needs of even the smallest hospitals.

"*The Canadian Hospital* has substance. Its articles are always well chosen and contain a lot of food for thought. It is evident that considerable research and conscientious work go into their preparation.

"Thirdly, *The Canadian Hospital* has a high degree of literary excellence. The form is pleasing and the matter always well written.

"A magazine possessing these qualities justifies its own existence. It deserves to continue to live and this is why we, the Catholic Hospital Council of Canada, wish for *The Canadian Hospital* long life and continued progress."

"Hector L. Bertrand, S.J., *President.*

Notes on Federal Grants

Cancer

Federal funds have been earmarked for the use of the Radium Institute and the Cancer Institute of Montreal. The grant to the former will enable it to extend its work of free diagnosis and treatment. The medical section of the newly-created Cancer Institute at Notre-Dame Hospital will be devoted to preventive work, to diagnosis of cancer, treatment by x-rays, radium and surgery, and research. The social service department will be extended, and an educational division will be set up to keep the public informed of latest developments and the medical profession abreast of newest techniques, diagnoses, and treatments.

* * * *

Tuberculosis

The federal government has approved the purchase of a new mobile x-ray unit for community tuberculosis surveys in Ontario and the addition of staff to carry out the various projects underway.

* * * *

Construction

Progress payments have been made toward the building of Laflèche Hospital, Grand' Mère, Quebec, and the Gilbert Plains Hospital, Gilbert Plains, Manitoba. Laflèche Hospital is the first one in Quebec to be assisted by federal grants and it will receive a total contribution amounting to about $116,000. The federal government has also agreed to grant $55,000 toward the cost of constructing the new Lunenberg Hospital in Nova Scotia.

* * * *

Crippled Children

Federal funds for work among crippled children will permit staff of the Woodeden Hospital Training School near London, Ont., to be given special training. Present plans call for the opening of Woodeden as a year-round centre exclusively for the treatment of children with cerebral palsy. Up to now it has operated for 13 weeks each summer as a camp for children suffering from various crippling diseases.

* * * *

Mental Health

Federal funds have been allocated to Prince Edward Island for the appointment of a medical psychiatrist to organize and conduct an active treatment centre at Falconwood Hospital and for the organization of a field branch of the proposed provincial division of mental hygiene. Clinics will also be established at Sydney and Yarmouth, N.S., and Fairville, N.B. The travelling clinic at Edmonton, already functioning, will receive assistance. In all these clinics, special attention is given to child guidance in co-operation with community service organizations and consultative services will be provided to local physicians. Each clinic will be staffed by a psychiartist, a psychologist and social workers.

The federal government will contribute approximately $122,000 toward the cost of equipping the new Crease Clinic of Psychological Medicine, and of providing additional equipment for the provincial mental hospital at Essondale, B.C. The Crease Clinic, now under construction on the grounds of the provincial mental hospital, will be an active treatment and research centre for short-term patients. Teaching facilities will be provided for both graduate and under-graduate medical students.

* * * *

Public Health

A new public health laboratory is being set up in Calgary at a cost of more than $27,000. Its services will be made available not only to doctors and nurses employed by provincial and municipal governments but also to private practitioners.

* * * *

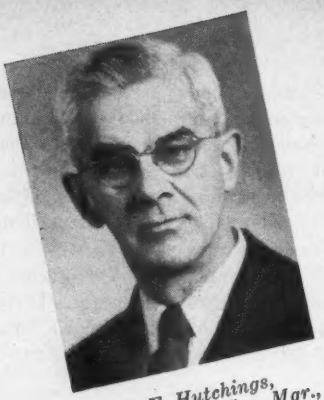
Federal funds will help to double the size of the school for nurses at the Herbert Reddy Memorial Hospital, Montreal. The contribution has been set aside for purchasing furniture and equipment, for increasing the library, and for the establishment of a science laboratory.

* * * *

X-ray Units

The federal government has approved an appropriation of $110,000 for the purchase of 11 x-ray units to provide chest x-rays for all patients entering British Columbia hospitals. The equipment will be loaned to general hospitals and in some instances it may be possible to lend the equipment to health units in strategic centres for community surveys.

T. B. James, President, J. F. Hartz Co., Limited.



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Greetings from

Since we announced that this issue would commemorate the founding of THE CANADIAN HOSPITAL in February, 1924, we have received many expressions of goodwill and best wishes from our advertisers and other business associates.

We sincerely appreciate these kindly thoughts. We have been extremely fortunate in numbering among our friends many executives who have made outstanding contributions in the development of hospital techniques, equipment and supplies designed to improve hospital procedures and to enable hospital administrators to better

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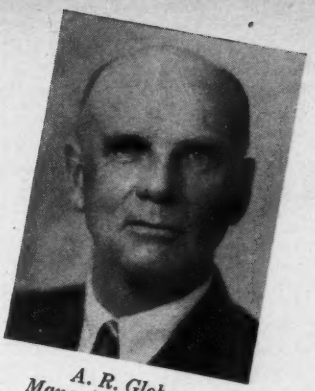

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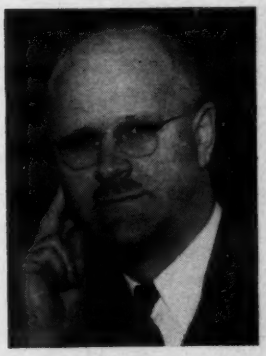

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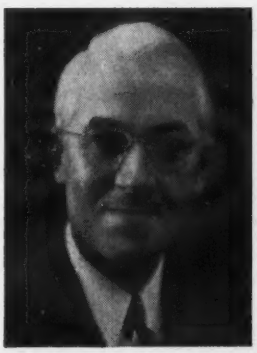
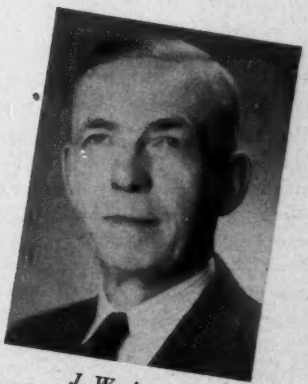


Charles A. Edwards,
Founder, The Canadian Hospital.

care for their patients and staffs.

Around the margin of this message are the portraits of a number of friends whose firms gave us generous support and encouragement during our first year of serving the hospital field. To all our friends, old and new, many thanks, sincere appreciation of your co-operation, and best wishes in the years to come.



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Food and Its Service

Sponsored by the Canadian Dietetic Association

Part II

Planning and Organizing a Dietary Department

Mary W. Northrop, M.S.,
Chief Dietitian and Housekeeper, King County Hospital System, Seattle, Washington.

BESIDES the physical plant and labour, an obvious and important component of food production is food itself. Let me repeat that decisions on this subject must be left to the person who is held responsible for the results. It is not fair to criticize a dietitian for the dissatisfactions of the consumer unless she is given the authority to decide on the means for securing satisfaction. The dietitian must be expected to stay within the limits of a budget but it is for her to decide how to do so. I knew a dietitian once who was trying to grow parsley in window boxes in a New York kitchen because the purchasing agent would not buy it for her; another who was refused maraschino cherries as being too expensive, when she knew perfectly well that half a cherry would "sell" a serving of inexpensive dessert and would more than pay for itself; and another who was at her wits' end trying to get people to eat cabbage every day for a week because the purchasing agent had found a bargain. The dietitian should know what her budget is and should be kept constantly informed on prices and expenditures. The budget may need to be adjusted to radical changes in wholesale price indices. From that point, it is her responsibility to see that she comes out right.

Internal Organization

The internal organization of the dietary department will depend on the opinions of the administrator and the dietitian of the particular hospital involved, as well as on the size of the hospital, the shape of the building, the elaborateness of the service standards, and various other pertinent factors. But certain fundamental principles always apply:

1. Wherever two people work together there is need for organization.
2. Organization is essentially a process of logical divisions and relationships.
3. Division is necessary to separate a total undertaking into component parts (each small enough to be handled by an individual) by a method that enables all to work together.
4. A plan is necessary to coordinate the activities of all divisions of an organization.
5. Simplicity in an organization plan is a mark of "know-how".

Complicated organization plans always make me think that the person who was setting them up was not quite sure of herself.

Schedules

The first step in organization will be the establishment of time schedules as they affect and are affected by the schedules of other departments. The hours that the store-room is open will determine the time that supplies may be expected to arrive in the kitchen. The ward schedule will be interlocked with the time of tray service. Meals in the dining-rooms will need to be served at hours suited to the schedules of all the departments whose personnel are to eat there. Since the internal schedule of the dietary department is dependent on these relationships, conferences with the heads of all other departments involved will be required. Compromises on both sides will have to be arrived at before the working schedule is made.

With meal service hours as the focal point, an analysis must then be made of the work-hours required in preparation for and in clearing up after this service. It has been found convenient to plot such an analysis on cross-ruled paper,* using the horizontal direction to represent time, each square being a quarter or half of an hour. All hours should be shown from six o'clock in the morning until seven in the evening. The resulting chart will have a series of pyramids showing the peak loads in each process. From this can be judged the number of workers required at a given time. There will be uneven spots in the chart but fortunately there are also certain jobs, such as cleaning, which may be done at one time as well as at another and which are best done at hours when the department is not too busy. These will be used to fill the chinks. In other words, you first make up a chart showing what has to be done at certain hours. You may have three people serving trays all at one time; then you fill in the time of those three people with essential jobs such as setting up salads or clearing trays. There may still be 15 minutes or half an hour or more free in the working hours of these people. That is where you work in your cleaning schedule and you will find that these odds and ends of time always come during the hours when you would want the cleaning done anyway.

You are then ready to plan the schedule for the individual worker

From an address presented at the Western Canada Institute for Hospital Administrators in Vancouver, 1948.

**See "A Graphic Personnel Schedule" by Mary W. Northrop and Nena D. Osterud, Journal of the American Dietetic Association, Jan. 1933, p. 423.*

and another piece of cross-ruled paper may be used for that. As before, the horizontal is used to denote time. On this chart each worker will occupy one line, his time will be shown, including his rest periods and his meal hours, and the various jobs that he does at different hours may be written in or shown by crayons of different colours. Whereas the chart showing the analysis of the whole operation is only for the use of the dietitian as a tool in planning the full schedule, this final chart may be posted on the kitchen wall to serve as a guide and a schedule for the employees.

Job Break-down Sheet

Finally, each operation on the above mentioned charts is analyzed on a "job break-down sheet"; and by "operation" I mean a pretty fine sub-division such as setting up the trays or making a certain kind of salad, not making salads in general. It could, of course, mean preparing lettuce in general. Loading dishes into the dishwashing machine would be one operation and cleaning a refrigerator another. In other words, I am talking in terms of rather trying sub-divisions of the work. In our own hospital there are twenty-five job break-downs for pantry maids alone. It is easier for you to teach if you do so according to small units of work. The job break-down is the instructor's manual for use in training employees.

In making these job break-down sheets, conferences will be needed among all the people involved in training employees in order that a standard procedure may be arrived at. The sheets represent the considered judgment of management as to the way each operation is to be performed. They should also take into consideration the lay-out and equipment of the working unit and must, therefore, be done afresh for each individual dietary department. There are very few of them which can apply to just any dietary department and very few can be adapted to any department other than the one for which it was made.

These job break-downs must have a try-out performance and will undoubtedly undergo many modifications before they are finally approved and put into service. However, they should assure standardization of both methods and results and they should provide for the efficient use of labour, which in turn makes possible and justifies higher wages.

In a new hospital it is easy to plan the organization as outlined above, for one does not have to overcome resistance to change. In an existing organization it will not be easy but it is nevertheless important that the table-top model be always in use as a tool in the search for improvements. Human nature, and especially employee-nature, being what it is, changes will usually have to be made gradually but they must be made. Change, after all, is universal and hospitals must realize that, since nothing is static, the organization which does not push ahead will soon slide backward. The key word of the whole system outlined here is *plan*, and then *plan*, and then *plan*.

Dr. Helen MacMurchy Honoured in U.S.A.

On January 23rd, Hobart and William Smith Colleges of Geneva, New York, held a special convocation to pay honour to leaders among women in the field of medicine today. The occasion was the Centennial Anniversary of the graduation of Elizabeth Blackwell, the first woman ever to receive the degree of doctor of medicine from a recognized medical school. Centennial citations were presented to ten outstanding women physicians, nominated by deans of medical schools to represent all the worthy successors to Dr. Blackwell.

Among those honoured was Dr. Helen MacMurchy, C.B.E., formerly chief of the Division of Child Welfare, Department of Pensions and National Health, Ottawa. Dr. MacMurchy was graduated from the University of Toronto in 1899 and later worked with Sir William Osler at Johns Hopkins Hospital, Baltimore, in the field of child welfare and public health. She also made special studies in this field in England (London and Manchester) and in New York, Boston, and Cleveland. While practising in Toronto between 1905 and 1920, she taught obstetrics and gynaecology at the University. She is the author of several text-books on child health and has represented Canada at many international conferences. Dr. MacMurchy is, of course, best known for her work in the Division of Child Welfare where, during her thirteen years in office, she accomplished so much in reducing maternal and infant mortality in this country. She is now 86 years of age and resides in Toronto.

Miss M. E. Fitzgerald Retires

Miss Matilda E. Fitzgerald, retiring secretary-treasurer of the Registered Nurses' Association of Ontario, was honoured by the board of directors at a luncheon. It was in 1926, a year after the Registered Nurses' Association had succeeded the Graduate Nurses' Association, that a decision was first made to employ a part-time secretary-treasurer. Miss Fitzgerald was appointed to this position and, in 1927, began a work which has since grown and developed beyond the most ambitious dreams and hopes.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

King Edward's Hospital Fund have announced an interesting development which, besides being useful to hospitals in Great Britain, is likely to be welcomed by all who are engaged in hospital activities in countries overseas.

The official title of this new section is the "Division of Hospital Facilities". The first impression conveyed by this title may quite well be something different from the actual intention. In the minds of some it may be more analogous to the division of the Fund's work which is known as the "Emergency Bed Service". The aim of that department is to provide facilities for the admission of patients to hospitals through a central clearing office. That, however, is fairly well established in the minds of medical practitioners and hospital staffs so that the new department will be recognized as something different from it. The official statement states that: "This Division will comprise an information bureau; an advisory service; a library of hospital books, journals, and plans; and an index to the hospital literature of Great Britain and other countries." When it is realized that the master mind behind this conception is Captain J. E. Stone, C.B.E., then it will be appreciated by the many who know him that the King's Fund "Mine of Information" is likely to be a more graphic method of describing the new division.

For many years hospital authorities have felt the need for some centre of information of this kind. It was a dream of the late Mr. R. P. Orde in connection with the work of the British Hospitals Association. The King's Fund initiated a number of special inquiries which resulted in the publication of reports upon matters of general interest, including more than one upon some aspect of the nursing problem. These publications have been welcome to hospital authorities, whether voluntary or municipal, though perhaps in some cases rather with the attitude of *faute de mieux*. Now that the King's Fund have placed the whole of this work on a definite basis it should be possible to raise the standard so that the somewhat amateurish treatment in previous inquiries is replaced by expert scientific methods of investigation. At this point the activities of the Fund impinge closely upon the work of the Nuffield Hospital Trustees. At the present time they have in hand with the University of Bristol an important investigation to "look very carefully at the distribution of work in caring for the sick and in promoting health to see whether improvements might be brought about by an alteration in the balance of work now shared between hospitals, general practitioner, and other health agencies". The official statement clarifies the situation by stating: "The King's Fund feel that the services of this division will be useful to hospital authorities and their officers desirous of obtaining a comprehensive review of thought and practice in hospital organization and management, et cetera". It is to be a centre for the dissemination of information as distinct from an organization engaged in actual research.

King Edward's Fund Establishes New Service Division

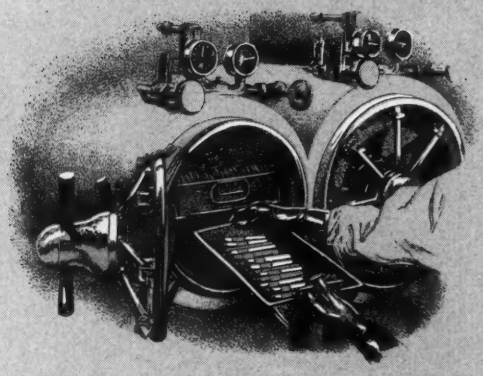
As the King's Fund have always been associated in the public mind with voluntary hospitals there may be an idea that this new development has some similar kind of limitation. In fact, the new national health service act is intended to remove those distinctions. Apart from that the King's Fund, under the terms of the statute providing it with a constitution, was for all hospitals, and the word "voluntary" does not occur in it. That being the case, it may be thought that the work now being undertaken by this division should be really a branch of the Ministry of Health, especially in view of its new relation to the whole hospital service. In practice, however, this kind of undertaking is much more effective and acceptable under voluntary rather than official auspices. You know, Sir, that inquiries go more readily to you than to the Minister of Health. I have no doubt that Captain Stone will give a welcome to any inquiries of your readers which they could never reasonably expect from a government department. There is a reciprocal aspect of that proposition. Information can be supplied from unofficial sources in a way which is not possible by those who have the responsibility of office. So from every point of view this departure of the King's Fund is one which will be received with acclamation.

On Rising Costs

"Cost of running hospitals has increased with the rising cost of living. Costs for 1947 show the following increases over 1939 for certain significant items: food, 69.9 per cent; fuel, 65 per cent; wages, 99.6 per cent . . . Overall costs in 1947 were 14 per cent. over 1946; 1948 costs are 15 per cent. over 1947 . . .

"Along with the rising costs of operation it is found that hospitals today are being used more than ever before. In 1939 one person out of ten required hospital care while in 1948 one person in seven goes to the hospital. Many an illness formerly treated at home is now treated in a hospital. New medical techniques, new drugs, and improved hospital services make hospital care increasingly essential in case of sickness."

—Manitoba Co-Operator, Oct., 1948.



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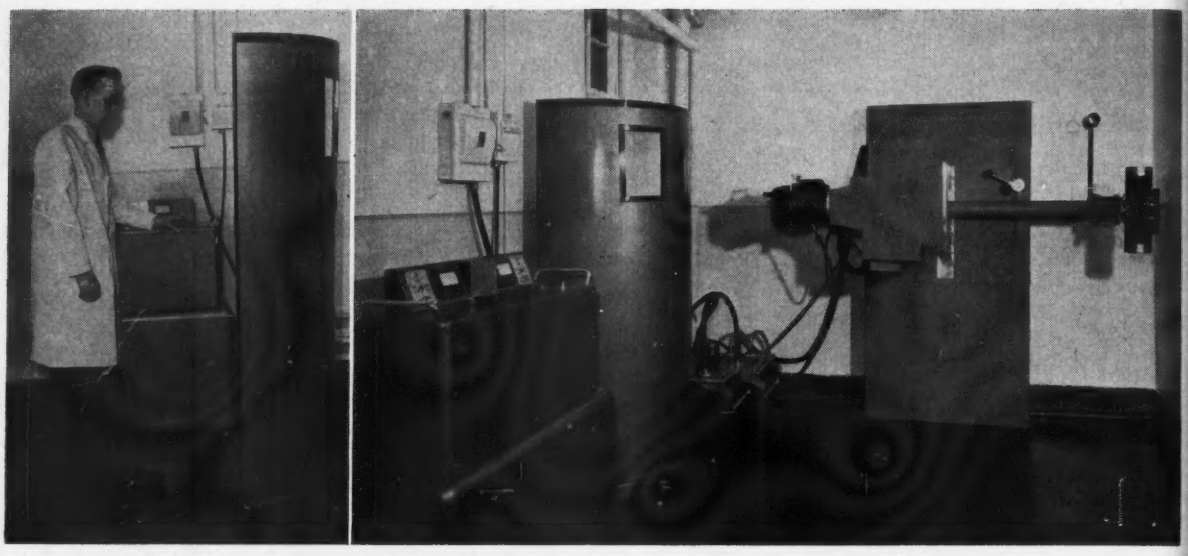


New Miniature X-ray Equipment Installed at Toronto Western

THE Toronto Western Hospital is one of some fourteen hospitals in Ontario which have installed routine admission chest x-ray units. Under the federal grant units are made available without charge to approved hospitals in that province, and many hospitals are only awaiting arrangement of accommodation and delivery of equipment to participate in the anti-tuberculosis program.

Pictured here is a Philips-Burke type 70 mm. film x-ray machine operated by Tom Bell, radiographer of the Toronto Western. The equipment consists of three components, mechanical, x-ray, and photographic. The mechanical section is a wall panel which holds the x-ray tube, the hooded screen, and the camera. Easily manipulated positive controls permit these to be raised or lowered as required and to rotate through an arc of more than 90 degrees. Thus the machine can readily be used to view patients in both standing and prone positions.

A rotating anode tube energized at 100 milliamperes with 100,000 volts is used. The high intensity X radiation passes through the patient and leaves a fluorescent image of the patient's chest on the screen within the hood. The intensity of the radiation can be controlled by the technician so as to compensate for extreme density or other factors. The technician operates the unit from the control panel, protected from harmful radiation by an approved screen.

The fluorescent image on the screen is photographed by a camera which is the Fairchild motor-driven F-212 type, arranged for automatic transport of the film after each exposure. The camera magazines will hold 100 feet of 70 mm. unperforated film sufficient for 375 images (2½" by 3") in one loading. The lens, with a rated speed of F. 1.5 and a focal length of 111 millimetres, is designed for the purpose of miniature radiography exclusively. In smaller hospitals where the number of admissions do not justify the use of roll film, the camera can be equipped with a cut-film adapter back for use of single film.

The exposure is automatically controlled by a Morgan Phototimer situated in a cabinet under the control panel (see picture). This phototimer comes into action as soon as the x-ray is turned on, and turns it off again as soon as its setting for photographic density is satisfied, thus assuring uniformity of contrast in all negatives.

The 70 mm. film, which is now almost universally accepted for this kind of work, was initiated in Ontario and the Morgan Phototimer is made in Toronto by Burke Electric and X-ray Company.

From data supplied by I. D. Willis.

WANTED—

Copies of Hospital Constitutions and By-laws

Due to the expanded hospital construction program, the Library of the Canadian Hospital Council is being deluged with requests for sample copies of by-laws and constitutions to be used as guides by new hospitals in setting up their regulations. In order to fulfil these requests we would appreciate your assistance.

If, within the past three or four years, you have prepared a new constitution, drawn up new rules, regulations or by-laws, or revised your existing constitution, will you please forward to us two or three copies. These will greatly aid us in circulating to other hospitals such information as they may need. Address to: The Library, The Canadian Hospital Council, 280 Bloor St. West, Toronto.

Health Care Plans

Ontario Blue Cross Adjusts Rates to Meet Rising Costs

To Start Individual Enrolment

The Minister of Health has authorized the Ontario Plan for Hospital Care to revise its rates in view of the higher cost of providing service. The new rates, applicable March 1, have been worked out in the light of recent hospitalization experience and established a precedent inasmuch as a two-rate plan is being developed with employed groups being offered a "preferred" rate.

Rates per month, old and new, are as follows:

Payroll Groups	Old	New
Standard, single	$ .75	$ .95
Semi-priv., single	1.00	1.30
Standard, family	1.50	1.90
Semi-priv., family	2.00	2.60
Non-Payroll Groups—nurses' alumnae, farmers, women's associations, special collection groups, and bill direct subscribers.		
Standard, single	$ .75	$1.15
Semi-priv., single	1.00	1.55
Standard, family	1.50	2.30
Semi-priv., family	2.00	3.10

The incidence of hospitalization which was 111 in 1947 rose to 128 in 1948. (This higher utilization is not an indication of greater use by Blue Cross participants, since the figure for the province as a whole was still higher—153.) Admissions for the year were approximately 145,000 higher than in 1947. The Plan pays the going rates of the hospitals which rose 24 per cent during the year. In paying the hospitals over $7,000,000 in 1948, the hospitals received 93 per cent of subscription income, leaving an inadequate amount for administration and necessary reserves. These figures reveal the value to the participant of full coverage rather than partial coverage through an indemnity plan.

Most extensive utilization and administrative cost arises in connection with hospital employees. Hospital employees average 181 per thousand with several running over 250. The length of stay for nurse alumnae groups (161 per 1,000) is two days over the average; for hospital employees one day over. There is a high utilization for "bill direct" subscribers—those who have left payroll deduction groups, including those who have retired. For these reasons it has been necessary to set a special rate for bill direct subscribers and special collection groups.

Blue Cross (Ont.) Enrolment Conference

Plan representatives from all over the province met at Toronto in December to attend a two and a half day enrolment conference. A group of the leaders are seen above, left to right: C. A. Sage, comptroller; Frank Van Dyk, vice-president of the New York Blue Cross Plan; D. W. Ogilvie, deputy director; J. H. W. Bower, chairman of the board of administration; Stewart Major, manager, Physicians' Services Inc., (O.M.A. Plan); R. A. Robertson, enrolment manager.

Individual Enrolment

In response to a widespread demand for individual enrolment privileges, the Board has decided to provide this coverage. The monthly rates will be:

Standard, single	$1.15
Semi-priv., single	1.55
Standard, family	2.30
Semi-priv., family	3.10

The benefits will be the same as for group-enrolled participants with certain restrictions: 12 months waiting period for pre-existing conditions; 12 months waiting period for pregnancy and complications; 6 months waiting period for tonsillectomies; admission age limit sixty, but may continue, not eligible if more than ten employees in the firm. The Plan is striving to bring individual enrolment into operation about April 1.

* * * *

A. M. A. Turns Down Blue Cross-Blue Shield Plan

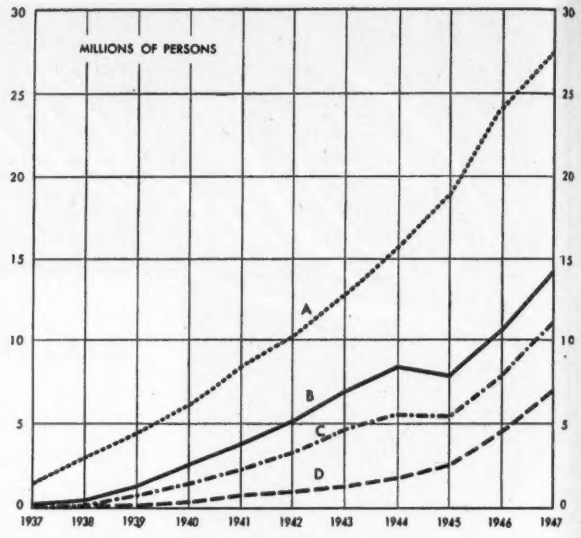
The proposed joint Blue Cross-Blue Shield program on a national basis, approved by the American Hospital Association in September, has now been turned down by the American Medical Association. Sponsors of this plan had hoped that voluntary medical and hospital plans could be linked together on a national basis to provide more adequate and more efficient coverage than has hitherto been possible. The action of the A.M.A. would seem to have weakened considerably the defences of those who have hoped that voluntary health care could be so developed that compulsory health insurance, now likely to be promoted with increased fervour at Washington, would not be necessary.

At the same time the A.M.A. is proceeding with its $25-per-member campaign to raise some $3,000,000 for a public education program on the merits of the present system of providing medical care.

Shortly after this action was taken, the trustees of the American Hospital Association again approved the plan for a national prepayment service as proposed by the Blue Cross Commission. It is

(Concluded on page 99)

High Percentage of U.S. Population VOLUNTARILY Carry Health Insurance Protection



Individuals Covered for:

A. Hospital Expense under Blue Cross.
B. Hospital Expense under Group Policies.
C. Surgical Expense under Group Policies.
D. Surgical Expense under Plans Sponsored by Medical Societies or Affiliated with Blue Cross.

Summary of Survey

(as of December 31, 1947)

Insurance Against Loss of Income Due to Sickness or Accident

A. Insurance Companies and Fraternal Societies	18,714,000
B. Paid Sick Leave—In Private Industry	4,560,000
In Civilian Government Service	4,490,000
C. Employee Mutual Benefit Associations	1,460,000
D. Union Plans and Other Employer-Employee Methods	2,000,000
Grand Total*	31,224,000

Hospital, Surgical and Medical Expense Coverage

	Hospital	Surgical	Medical
A. Insurance Companies, Hospital Insurance Companies and Fraternal Societies—Personal	10,548,000	8,687,000	1,463,000
Dependents	10,275,000	6,651,000	606,000
Total	20,823,000	15,338,000	2,069,000
B. Blue Cross Plans and Plans Sponsored by Medical Societies			
Personal	12,355,000	3,260,000	1,495,000
Dependents	15,631,000	3,820,000	1,490,000
Total	27,986,000	7,080,000	2,985,000
C. Other Organizations			
1. Bituminous-Coal Industry			
Personal	190,000	224,000	224,000
Dependents	250,000	300,000	300,000
Total	440,000	524,000	524,000
2. Consumer Sponsored	1,600,000	1,600,000	1,600,000
3. Industrial, not coal	1,260,000	1,220,000	1,215,000
4. Private Group Clinics	375,000	385,000	405,000
5. University Health Plans	100,000	100,000	100,000
Grand Total	52,584,000	26,247,000	8,898,000

*NOTE: This does not include individuals covered solely by government insurance under compulsory plans.

This summary was prepared by a special committee and released by the Life Insurance Association of America.

IN the United States more than 52,000,000 people are now protected under some form of voluntary hospital insurance (including Blue Cross plans)—56 per cent more than at the end of 1945 and 241 per cent more than in 1941. Voluntary surgical and medical insurance plans cover about 26,000,000 and 9,000,000 persons respectively. Over half the employed civilians (more than 31,000,000 persons) have benefits for loss of income due to disability.

These figures, representing the number protected at the beginning of 1948, are findings based on the first nationwide survey of voluntary accident and health plans embracing not only those protected by insurance companies but also those covered by Blue Cross and other such organizations.

The carriers insuring these people against hospitalization expense include: insurance companies and fraternal societies, nearly 21,000,000 covered; Blue Cross plans and plans sponsored by medical societies, 28,000,000*; plans in the bituminous coal and other industries, private group clinics, university health plans, and consumer sponsored groups, more than 3,000,000.

**Including the 2,250,000 covered in Canada, Blue Cross now has a coverage of 32,000,000.*

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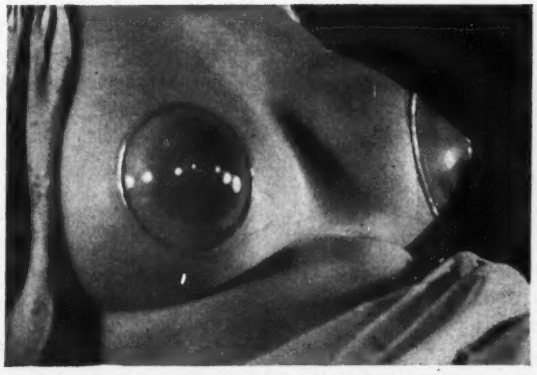
- PLASTISHIELDS are clean, simple to use and comfortably worn.
- They are easily sterilized and prevent soreness, cracking and fissuring of nipples.
- You are invited to write for further information on the PLASTISHIELD Technic of Aseptic Breast Care.

Plastishield technic of aseptic breast care



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Here and There

China Under Communism

THERE are so many conflicting appraisals of the situation in China that it is difficult to form a clear picture of the policies at issue. Both Protestant and Roman Catholic groups in Canada are deeply interested in the immediate fate and welfare of numerous hospitals and missions in that country, staffed and financed in whole or in part by our people.

One of the best commentaries on the present situation has been issued in letter form by Dr. Sherwood Eddy, the noted traveller, author, and lecturer, and by his wife, also a noted traveller and lecturer. Dr. and Mrs. Eddy are now touring these troubled areas and their regular letters, which we hope will appear in book form, constitute a veritable storehouse of unusually well screened and reliable information. For forty-one years, Dr. Eddy has been a periodic visitor to the Orient and knows personally and well most of the leading players in this great drama. Few visitors, if any, have ever had as ready entree to inner official circles.

Chiang Kai-shek will go down as one of the great names in Chinese history because he alone was able to unite China in the anarchic war-lord period and to hold China together through eight years of resistance to the armed might of Japan. But he, the Kuomintang Party, and the Nationalist Government have failed, after fair trial, in almost every area of China's life — military, economic, social, and moral. General Wedemeyer urged the removal of incompetent and corrupt people from positions of responsibility. But this was not done. Chinese officials are not paid their expenses. "A viceroy of two provinces," writes Dr. Eddy, "was paid by the Central Government but $300 a year, and though he received more from the provinces as an 'anti-extortion allowance', he had to employ an army of secretaries, assistants and troops to maintain order. He was expected to take a reasonable amount in presents, perquisites, commissions, and payments for his court cases. This developed not only the worst system of graft existing in the world, but the worst ever known in all history. It was government by organized corruption." Squeeze and nepotism enforced each other. Unavailingly General Stilwell urged that grafters be removed and that the troops be paid directly, without being robbed by their officers.

The Communist Party, about to become the twenty-sixth dynasty in 4000 years, is the largest, the best disciplined, and has the longest experience of any such party outside of Russia. They have learned some things pragmatically. Especially they have learned the failure of their policy of cruelty to foreigners and persecution of Christians as formerly practised by some of their fanatical commanders. They are, and always have been, real Marxists. Being realists they modify their program to suit rural conditions and have changed it entirely at times. "While they will always be loyal to Soviet Russia as against 'American capitalist imperialism', as Chinese they have always stubbornly resisted foreign domination, whether British, American, Japanese, or Russian."

Although the Communists began as a one-party movement, they instituted in 1944 the 3-3-3 system, by which not more than one-third of those elected to any county or regional council could be members of the Communist Party. A third had to be Kuomintang and a third non-partisan. Dr. Owen Lattimore in his *Solution in Asia* regarded this as "the most positive step by any party away from dictatorship toward democracy".

In North China the Communists seem to be seeking by trial and error to evolve a workable social system. Their final attitude toward Christianity will have much bearing on the welfare of China and the peace of the world. The change of attitude toward Christianity in Soviet Russia is recalled. Moreover the present slogan is "Freedom of Religious Belief". However, the Communist leader, Mao Tze-tung, in *China's New Democracy* (1944), writes, "Chinese Communists may form an anti-imperialistic united front politically with certain idealists and disciples of religions, but can never approve their idealism or religious teachings."

"It was natural," writes Dr. Eddy, "that the main attack of the Communists in China should be against the Roman Catholic Church, because of its large property and land holdings and because of its official world-wide opposition to Communism, that extends from the Pope down to every Catholic bishop in China . . . The attacks on Protestant missionaries have been principally against Americans, as 'imperialists' who help the reactionary government." A friend of Dr. Eddy was brutally tried for every death that had occurred in her hospital in thirty years. She was permitted no defense, nor was she allowed to deny the two hundred charges brought against her of having missionary doctors "cut people's hearts out allowing the poor to die while they saved the rich." The mission property was confiscated as part payment of the fines and she was evicted from the area.

Missionaries who, as UNRRA officials, moved freely in Communist and Nationalist territories for two years were generally agreed that the Nationalists were more favourable to organized religion and especially to Christianity. But in five respects the Communist areas were better governed:

1. The Communist Government

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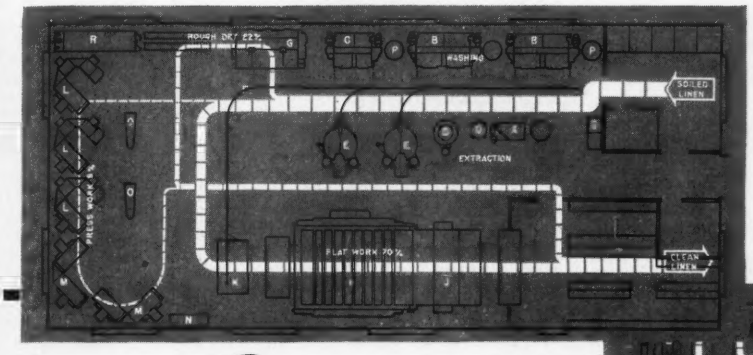

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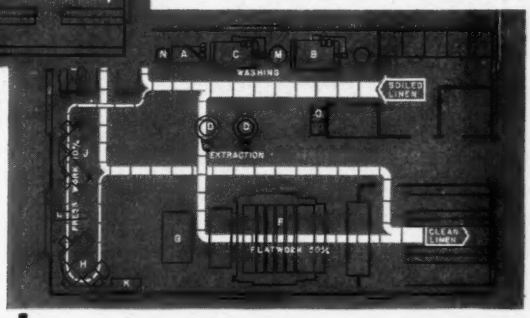
A Hoffman plan for correct flat-work, rough dry and press work capacities as indicated by preliminary study.



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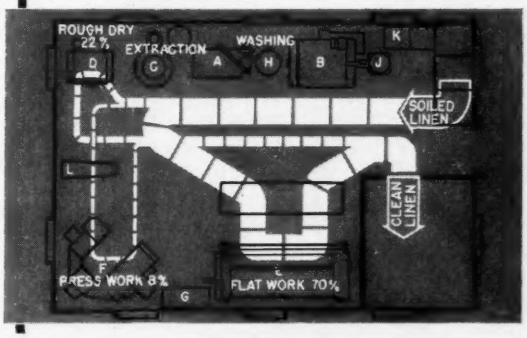

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was decidedly more efficient in providing for the people's livelihood and had its roots in the life of the peasants;

2. The Communist Government was free from graft, partly through "elimination" of grafters and partly because the absence of inflated currency lessens temptation;

3. Communist areas are free from beggary and hunger since land and productive employment are provided;

4. Communists are ruthlessly eradicating Confuscianism and are preaching the equality of sexes in a classless society and working towards compulsory education;

5. They have created a sense of community and personal responsibility. Students and graduates are being attracted by this program. Both Stalin and Mao Tze-tung were Asiatic peasants but Mao is free from Stalin's traits of suspicion and cold cruelty.

Dr. Eddy, noting that for many centuries, the Chinese have learned much from their conquerors, thinks that China may benefit under the stern discipline of the Communists. Perhaps the Communists will make the Chinese a literate nation. In May, 1948, Mao Tze-tung denounced attacks on missionaries and persecution of Chinese Christians; this policy is outlawed for the future. The Governor of the North China Border Region has proclaimed, "All citizens have a right to worship and to preach; at the same time they are free to disbelieve or criticize religion." In the Peiping area signs have been posted signifying the Communists' intention to protect "missionaries and capitalists" and to let all forms of mission work proceed as usual. Apparently some twenty mission hospitals are being carried on in North China. However, time will reveal the ultimate policy.

A sad commentary on the way in which people in the East (and apparently the same might be said of parts of Europe) accept the staggering sums of aid from America is Dr. Eddy's observation:

"From all sources, including governments grants, military supplies, UNRRA and all other relief, the United States has poured into China a little over a billion dollars a year for three years. Yet for all this I have never heard one word of gratitude or appreciation from any one in China.—*G.H.A.*

◀ Book Review ▶

THE STORY OF THE JOHNS HOPKINS. By Bertram M. Bernheim, M.D., Associate Professor (Emeritus) of Surgery, the Johns Hopkins Medical School. Pp. 235. Illustrated. Price $4.50. McGraw-Hill Company of Canada, Toronto. 1948.

There has always been more glamour about Johns Hopkins than about any other medical school on this continent. Perhaps this has been because of the developments associated with its unusual origin; perhaps because of the colourful quartet of celebrities-to-be who threw themselves into the task of organization with all the enthusiasm of youth; and perhaps because of the great leadership given by this new school right from the first. At any rate, the story of Johns Hopkins is the story of a new era in medical education and to review its early days is to pass again in retrospect some of the major milestones in modern methods of teaching.

Dr. Bernheim's book is essentially a personal record of one who has spent his entire adult life in that institution, first as a student and then as a staff member. It is not, the author makes plain, an official record with all the drabness and censorship which would accompany such a work. Being a personal record, the author can say what he pleases and he thoroughly exercises that privilege. His word-pictures of Osler, Welch, Kelly, Halsted, Howell, Abel, Mall, and others of that original group, are delightful reading. He tells of Johns Hopkins' blighted romance; of how Welch helped cure Halsted of the cocaine habit incurred while experimenting on the drug; of how Osler usually had the final year men over to the house Saturday nights to review the week's work over beer and pretzels; of how Hopkins men were poor in anatomy while Mall did the teaching or rather, didn't do it; of how Kelly often gathered the group together before an operation for a word of prayer.

This story is most informal and the author praises or criticizes as he sees fit—and as he probably did all his life. But it is a story of achievement and the men who crowd its pages are immortals. From "the moment the starting gun sounded, the Hopkins went to town. Literally, like a bat out of hell". The initial group were joined in time by equally brilliant younger men—Harvey Cushing, Finney, Hugh Young, Walter Dandy, and our own Tom Cullen among others. This university had many "firsts" to its credit—ranging from its emphasis upon laboratory medicine and the establishment of the first School of Art as applied to medicine under Max Brödel, to the establishment of the first American hospital unit in World War I and to the first School of Public Health. It is a good story and is well told.

Little Likelihood Change Isopropyl Alcohol Duty

There does not seem to be much likelihood of an increase in the duty on isopropyl alcohol. Information received by the Canadian Hospital Council from the Department of Finance would indicate little probability of "the tariff being increased on any commodity. Since 1936 the tariff has been increased on two products only. It would be difficult to advance logical reasons why the tariff should be increased on isopropyl alcohol and methanol in order to afford tariff protection to the producers of industrial alcohol."

Last autumn the British Columbia Hospitals Association, hearing of representations being made to have a protective tariff set up against isopropyl alcohol, now being used more extensively by hospitals instead of ethyl alcohol, passed a strong resolution opposing this move. Other hospital associations meeting last autumn supported this stand.

Isopropyl alcohol is now admitted duty free under the British Preferential Tariff. If imported from a most-favoured-nation the rate is fifty cents per gallon and from other nations, it is $1.00 per gallon. This rate has been in effect for many years.

Correspondence

Saskatchewan Replies

To the Editor:

I wish to thank you for the opportunity of publishing this reply to a letter from Mr. D. W. Ogilvie, Deputy Director, Plan for Hospital Care, Ontario, which appeared in this column last month.

It is suggested by Mr. Ogilvie, in connection with certain items on pages 43 and 44 of the 1947 report of the Saskatchewan Hospital Services Plan, that a comparison of administration expense as a percentage of total income is not an ideal one because of variation between different Plans in the amount of income per participant. The percentages mentioned in this part of the report are percentages of total expenditure and not of total income. Nevertheless, I agree with Mr. Ogilvie that the cost per head of covered population is a good basis for comparison of administrative costs.

As Mr. Ogilvie mentions, there are certain items included in the total of administrative costs which make it somewhat difficult to present a precise comparison between the operations of a government hospital care program and a Blue Cross plan. The Saskatchewan plan, for example, does not incur enrolment cost. Offsetting this, however, is commission paid to tax collectors. In 1947, such commissions totalled $182,642.08, or almost one-third of the Saskatchewan plan's total administrative costs.

A second item which would affect any comparison of administrative expenses is the fact that, in accordance with government accounting practice, certain capital items were included in the administrative expenses of the Saskatchewan plan during the year 1947. These items, which appear on page 72 of the plan's 1947 report, are as follows:

Office furniture	$ 6,991.02
Accounting machines and typewriters	10,310.42
Other office equipment	19,319.50
Total	$36,620.94

Such expenses, of course, are not of a regularly recurring nature.

A third item, which is mentioned by Mr. Ogilvie, is the cost of rent, electricity, light, and heating. The cost of such services is not included in the Saskatchewan expenses and is estimated at $12,000 for 1947.

If $12,000 were added to the Saskatchewan expenses for the cost of rent, electricity, light, and heat, and the sum of $36,620.94 subtracted in respect of capital costs, the figure for administrative expense would stand at $572,884.01. With an average covered population of 780,445, administration expenses for the year would, therefore, be 73 cents per capita.

I would point out that comments on pages 43 and 44 of the annual report of the Saskatchewan plan related to a comparison of administrative expenses with average costs experienced by 87 Blue Cross plans during 1946. The figures relating to Blue Cross plans were taken from *Blue Cross and Medical Service Plans*, by Louis S. Reed, published by the U.S. Public Health Service. On page 321 of this publication will be found the following information:

No. of participants, Jan. 1, 1947, in 87 plans	25,876,424
Total income, 1946	$171,673,168
Percentage of total income used for administration	13.01

From these figures it would appear that the average cost for administration expense was 86 cents per head of covered population among Blue Cross plans in 1946.

Administration expenses may, therefore, be compared as follows:

Ontario Plan, 1947	74 cents
Saskatchewan Plan, 1947	73 cents
Average of 87 Blue Cross Plans, 1946	86 cents

Another basis of comparison which might be considered by anyone interested in administration costs of health insurance plans is the cost per case. On page 113 of *Blue Cross and Medical Service Plans* the average number of hospital admissions per participant in Blue Cross plans in 1946 is stated as .1112. On the basis of this admission rate and the figures quoted above for covered population, total income, and per cent of income used for administration, it is calculated that the amount of administration expense per case was $7.76 among Blue Cross plans during 1946. The Saskatchewan plan's statistics are computed on the basis of discharges rather than admissions. It experienced a total of 121,951 discharges, not counting newborns, in 1947. Taking the figure of $572,884.01 as the Saskatchewan plan's net administrative cost for the year, the administration expense per case would, therefore, be $4.70.

Yours very truly,

"G. W. Myers",
Executive Director,
Saskatchewan Hospital Services Plan.

Coming Conventions

Feb. 21-25—A.H.A. Institute on Basic Accounting Piedmont Hotel, Atlanta, Ga.
Mar. 14-18—A.H.A. Institute on Dietetics, Biloxi, Miss.
Mar. 21-22—Sectional Meeting, American College of Surgeons, Statler Hotel, Buffalo.
Mar. 28-April 1—A.H.A. Institute on Public Relations, Chicago.
April 4-8—A.H.A. Institute for Medical Record Librarians, Buck Hill Falls Inn, Buck Hill Falls, Pa.
April 12-13—Sectional Meeting, A.C.S., MacDonald Hotel, Edmonton.
April 18-22—A.H.A. Institute on Hospital Purchasing, Wardman Park Hotel, Washington.
May 20-21—Canadian Society of Laboratory Technologists, Chateau Laurier, Ottawa.
May 26-28—Canadian Hospital Council Biennial Meeting, Quebec City.
June 13-17—Canadian Medical Association, Saskatoon.
Sept. 25-26—American College of Hospital Administrators, Cleveland.
Sept. 26-29—American Hospital Association, Cleveland.
Oct. 3-8—Western Canada Institute for Administrators, Regina.
Oct. 31-Nov. 2—Ontario Hospital Association, Royal York Hotel, Toronto.
Nov. 7-9—Associated Hospitals of Alberta, Calgary.
Nov. 17-18—B.C. Hospitals Association Convention, Vancouver Hotel, Vancouver.

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Provincial Notes

Nova Scotia

LUNENBERG. Construction of Lunenberg Hospital is well under way, with plans calling for its completion before the end of the year. The 55-bed hospital will be equipped to handle general medical cases and will serve a population of nearly 20,000.

New Brunswick

ST. STEPHEN. Due to ill health, Miss Reta Follis, Reg.N., has requested the board of Chipman Memorial Hospital to relieve her of her duties as early as possible. Since she assumed the position of superintendent in 1937, Miss Follis has seen the work in all departments of the hospital increase by about 100 per cent.

* * * *

STANLEY. Last fall residents of Stanley and the surrounding community staged a day-long auction sale which realized $1,500 for the new Memorial Hospital. Before the auction day trucks toured the district collecting offerings contributed by enthusiastic citizens. Then from dawn until dusk the traditional chant of four auctioneers rang out, disposing of farm supplies, stock, and household goods. The new Memorial Hospital at Stanley will be the sixth in the chain of Red Cross Outpost and Community hospitals in New Brunswick.

Quebec

JOLIETTE. Recently hundreds of citizens of the town of Joliette witnessed the official opening of the new St. Eusebe Hospital which is operated by the Sisters of Providence. The five-storey stone building will provide accommodation for 150 patients. The $1,500,000 project was wholly sponsored by the Sisters of Providence with the financial assistance of the Quebec government and the city of Joliette.

* * * *

GRAND'MERE. Laflèche Hospital is being built by La Congrégation des Filles de Jésus de Trois Rivières to serve an area having a population of approximately 90,000. It will have about 120 beds and will be fully equipped with x-ray, laboratory and surgical equipment to handle general medical and surgical cases. Begun in May, 1947, it is expected to be completed by next December.

* * * *

LA TUQUE. The official opening of the new wing of St. Joseph's Hospital, which increases the accommodation of the hospital from 65 to 120 beds, took place last December. The heating plant, laundry, and staff dining-room are located in the basement. The Indian wards and some of the private wards are on the second floor, the third floor is reserved for the orphanage, and the nuns occupy the fourth floor. Features of the wing are the intercommunication system and the radiant heating plant.

* * * *

MONTREAL. A site on which the new Julius Richardson Convalescent Hospital for children is to be erected has been acquired from the city of Montreal for the sum of $13,235. Now situated in Chateauquay Basin, with a Montreal office in the Medical Arts Building, the hospital cares for children between the ages of three and twelve years who require convalescent care after being discharged from regular hospital treatment.

* * * *

MONTREAL. A total of 393 years of voluntary service to the Herzl Dispensary and Hospital has been represented by 27 Montreal doctors. To honour their services, the doctors were presented with parchment certificates and pen and pencil sets. Drs. M. Rabinowitch, S. F. Stein, and D. Tannenbaum each had 36 years of such service to their credit at the Dispensary. While the Dispensary has recently been closed, the Herzl Health Centre, another service of the Federation of Jewish Philanthropies, will continue to serve the community in the field of preventive medicine and for the benefit of children.

* * * *

SHAWVILLE. A special grant of $50,000, made payable in the amount of $10,000 per year for five years, has been authorized by the Quebec Government to the Pontiac Community Hospital. The new 52-bed hospital, built and equipped at a cost of $300,000, was officially opened last November.

Ontario

HAMILTON. Early in January, a rate increase schedule came into effect at the Hamilton General and the Mount Hamilton Hospitals. This calls for a $1 per day increase for all adult categories, whether pay ward, semi-private, or private, and a $2 per day increase for all paying patients who are not residents of Hamilton.

* * * *

LONDON. Driving about 120 mental patients from their beds, a fire in the floor of a three-storey unit at Westminster Hospital caused damage estimated at $1,000. Great credit was given to the work of the orderlies and nurses who guided the patients to safety in another ward.

* * * *

LONDON. The board of the War Memorial Children's Hospital has recently announced plans to construct a new three-storey wing and to renovate completely the old building. The wing will add 44 beds to the present accommodation and the cost of the entire project is estimated at $485,000.

* * * *

MARKDALE. The Centre Grey Hospital Board has arranged to purchase for the sum of $50,000 Dr. R. L. Carefoot's Private Hospital. The Board was formed for the purpose of

acquiring the hospital and converting it into a public institution.

* * * *

ST. CATHARINES. Miss Alice M. Vasey has been appointed chief dietitian of the St. Catharines General Hospital. A graduate of the University of Manitoba, Miss Vasey has been chief dietitian at the Winnipeg General for the past three years.

* * * *

ST. CATHARINES. Tax-payers have endorsed the proposed construction of a new Hotel Dieu Hospital. The five-storey building will provide complete hospitalization services and accommodation for 125 patients and will cost an estimated $1,250,000.

* * * *

SMITHS FALLS. Miss Evelyn Wood, Reg.N., of Sherbrooke, has assumed her new duties as superintendent of the Smiths Falls Public Hospital. Miss Margaret Moag has been acting superintendent since last July.

Manitoba

BRANDON. As an objective for 1949, the Kiwanis Club is undertaking to provide a modern children's hospital at a cost of $15,000. It is not proposed to erect a new building but to remodel a portion of the Brandon General Hospital to make a modern unit for the treatment of sick children.

* * * *

DAUPHIN. A new $100,00 health centre adjoining the Dauphin General Hospital was opened last month. The two-storey building will house the local health unit and district welfare offices, diagnostic services for the area, a lecture room, and x-ray equipment. Of reinforced concrete and stucco construction, the health centre was financed by the provincial government and will be operated jointly by the province and the unit, with the province paying up to a maximum of 50 cents per capita.

* * * *

GILBERT PLAINS. The Gilbert Plains Hospital, now half completed, will provide the equivalent of 12 beds for general medical cases and will have facilities for minor surgery. It will also contain offices for two doctors and space for a public health nurse. At present the nearest general hospital is in Dauphin 20 miles away.

* * * *

HAMIOTA. Ratepayers of Hamiota Hospital district voted in favour of the money by-law for the establishment of a new 26-bed hospital in the village of Hamiota, and for the erection of three small nursing units in Kenton, Oak River and Miniota. Hamiota will receive a total of $42,000 from the Dominion and Provincial governments and a donation of $3,000 from the Manitoba Pool Elevators. Further expenses will be met through direct municipal taxation.

* * * *

WINNIPEG. Last December, the Misericordia Hospital celebrated its 50th anniversary. At a banquet held in honour of the occasion, Rev. Gerald Murray, coadjutor-archbishop of Winnipeg, the guest speaker, paid special tribute to Sister Superior St. Gertrude and her staff.

* * * *

WINNIPEG. Through its memorial hospital fund, Manitoba Pool Elevators has contributed $36,000 to hospital construction in Manitoba during the past three years. The sum is made up of $3,000 grants donated to hospitals built in 12 Manitoba municipalities. Payments were made when the projects were approved by the department of health and favoured by a vote in the areas.

Alberta

EDMONTON. Effective January 1, the pay cheques of employees of the Royal Alexandra Hospital were increased by 10 per cent. These increases, announced as part of new union agreements, are based on the October 1, 1948 index, which was 159.7. The adjustments will be computed every three months as the cost of living varies. For the 11-month period of 1948, the cost of operating the Royal Alexandra was $1,151,000; for the same period in 1947, the cost of operation was $914,000.

British Columbia

VANCOUVER. The Vancouver General Hospital has resumed its pre-war allowance rate to student nurses in their graduating year. During the latter part of the war these nurses were paid, in addition to their basic $10 per month allowance, an extra $15 if they stayed in residence and $25 if they lived out. This compensated for the added responsibility which they were expected to assume under the pressure of war.

* * * *

VANCOUVER. The provincial government is drawing up plans for the erection of a convalescent hospital on the grounds of the Vancouver General Hospital. With accommodation for between 250 to 300 patients, the hospital will be an important project in the current $10,000,000 building program in operation at the Vancouver General. An 825-bed acute hospital, containing all the utilities, will help to double the present bed capacity. The cystoscopic unit, x-ray department, medical records room, and dietary departments will be expanded, and construction will commence on a post-operative room, a premature nursery, surgical supply centre, and a $2,500,000 nurses' home.

* * * *

VANCOUVER. Meals are now *a la carte* at the Vancouver General Hospital. Private patients are supplied with printed menus on which they can tick off the dishes that appeal to them or indicate some other dish they may fancy that is not on the list. This service will be extended to public wards as soon as it has a thorough try-out. Up to the present there has been a considerable reduction of waste in discarded food.

A.C.H.A. Roster, 1949

The 1949 Roster of the American College of Hospital Administrators, which has just been published, lists among its active members a larger number of Canadians than in other years. There are 3 honorary fellows, 11 fellows, 33 members, and 43 nominees. As well as those resident in Canada who are included in these figures, there are many former Canadians now living in U.S.A.

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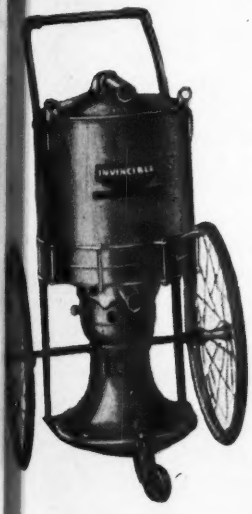

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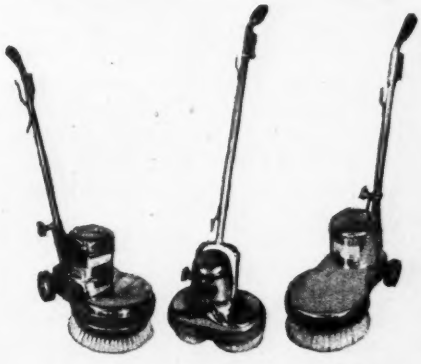

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Budget Planning

(Continued from page 53)

and finance. Departmental budgets should then be summarized to show the total anticipated expenses required for service without change in standards, and to show the additional cost of the proposed changes in standards.

The third step, which could be carried on concurrently with the development of an expense budget, is the preparation of the income budget. Having obtained the anticipated volume of service, and knowing the present average income from the units of such service, the income budget is first prepared without rate changes. The prime difference between the income budget and the actual income of last year is the difference in the volume of service.

These income and expense budgets should then be brought together, following the pattern used in your Summary Statement of Income and Expense, thus arriving at the anticipated deficit. From this point, over-all policy judgment comes into the picture to determine whether rates should be changed and what, if any, advances in standards should be carried out for the coming year.

It is most helpful for the administrator and the controller to review each departmental budget at this point and discuss the programs which department heads have outlined for the coming year. After considering all the hospital's proposed activities, certain programs can be eliminated immediately and others changed so that efficient operation is maintained for the hospital as a whole.

Monthly Budgets

To determine how actual experience is fitting in with planned experience for the year, it is necessary to break the annual budget into monthly budgets. In building these, seasonal variations in service should be considered, e.g., very hot or very cold weather, vacation periods, et cetera. Although one-twelfth of the annual budget is a better working basis than a comparison with expenditure for the same period of the previous year, a modification for seasonal problems is well worth the effort.

Each department head has built his own budget and has acquiesced in the final allotment; therefore requests for exceptions from the budget should be discouraged. It is possible to make most of the expenditures of the hospital routine and so provide time for consideration of exceptional problems. Budget figures are presented with the actual figures and any deviations from the planned operation are easily determined. Amazing efficiency is achieved through developing and following a budget.

Mechanics of Budget Building

It will be useful to know some of the mechanics of budget preparation. In planning patient days, lay out a work sheet showing, for each nursing unit, the patient days and the percentage of occupancy for the past three years. Then list separately the major outside factors which may affect the census, for example:

1. New buildings in the hospital area;
2. Formation or growth of prepaid hospital care plans;
3. Change in the economic status of area;
4. Changes in policy of government agencies;
5. Change in medical staff of other hospitals in area;
6. Changes in rates of other hospitals in area.

Next list the major inside factors which may affect the census, for example:

1. New buildings of the hospital;
2. Expansion of clinic facilities;
3. New adjunct care facilities or policies;
4. Changes in medical staff;
5. Changes in public relations policies;
6. Changes in admission or credit policies.

Having listed the major factors which would affect patient days, decide the probable percentage of occupancy for each of the nursing units, taking these factors of change into account. From there it is a mathematical problem to determine the probable number of patient days. The percentage of occupancy is found to be a more accurate estimate in arriving at patient days than to determine the patient days directly.

In building the income budget, it is necessary to determine the average rate per service unit for the last year, if possible, but certainly for the period (if less than a year) since the last rate change was effected. This should be done both for the routine care accommodations and for the adjunct services. The frequency of the use of adjunct services per patient day should be calculated for the last year. These are the basic factors required for estimating the gross income from patients. The estimate of reduction of earnings must consider the indigent allowances of the last year plus the effect of changes in either inside factors or outside factors. Each of the other classifications of reduction of earnings must similarly be calculated.

Supplementary income must be analysed to determine if there are any changes likely to occur in that area of income.

At this point, there is no change in rates. These will occur only after the expense budget has been correlated with the income budget and the general policy determined.

In determining the expense, it is desirable to itemize the individual positions in a department and estimate the effect of the current wage policy so as to be sure that adequate provision has been made for automatic salary increases and vacations. A discount must be made for those increases which will not occur because of turnover of personnel.

The supply expenses of the previous year must be adjusted to reflect both the anticipated service volume and price levels. The changes in departmental programs should be separately calculated to show their total effect in the budgeted year. It is wise to remember that a proposed program change will be effective for the whole of the following year even though it is to be put into effect for only part of the budgeted year. It is also well to keep in mind that additional personnel consume additional supplies.

The budgets of each department should be combined into a master budget of expense. The process of making a general budget is to summarize the income and expense in detail corresponding to the Statement of Gain or Loss, showing the actual gain or loss for the last

(Concluded on page 102)

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"The Canadian Hospital" Offers Awards for Best Articles

THE Editorial Board of *The Canadian Hospital* again announces that it will make its annual award of one hundred dollars ($100.00) for the best article published in 1949. For the second article selected, there will be an award of fifty dollars ($50.00).

These awards are for articles which, in the opinion of the judges, best display:

a. Soundness of viewpoint
b. Originality of thought
c. Practicability
d. Personal research
e. Good writing
f. Attractiveness of presentation.

Conditions

1. Judges will be the members of the Editorial Board of *The Canadian Hospital*, and their decision will be final.

2. Articles submitted must be on some phase of hospital work, or deal with socio-economic movements related to hospital activities, in this country or elsewhere.

3. Articles should be of 1,500 to 3,000 words in length, although these limits are not necessarily obligatory. Articles should be typed, double spaced and on one side of the sheet only.

4. Any article received may be published in *The Canadian Hospital* and the Canadian Hospital Council, through the journal and its bulletins, shall have the sole right of publication.

5. Any person engaged in hospital work, or in a field related to hospital work, and who is not a professional writer, will be eligible for this award, irrespective of the country in which he resides.

6. Articles received but not published in 1947 are eligible for a 1948 award; articles received in 1948 but not published until 1949 will be eligible for the 1949 award.

Awards for 1948 will be announced shortly.

When sleep puts an end to delirium it is a good sign.—*Hippocrates.*

Dancing Hormonies

(Concluded from page 43)

Transformations, carefully removed after trips to the T.S.O., reposed in every pocket under the white apron, ready to be clamped on immediately at the sight of a white uniform. One year later acceptance was general. Patients, doctors, and our superiors, placed their stamp of approval on the "bob" and we once more settled back to our daily tasks. Another milestone in nursing had been reached.

The remaining half year passed rapidly. Our anaphylactic foxtrot reactions were stimulated periodically by the changes brought about by the discovery in hiding of some of our co-partners on the Islands of Langerhans. This led to great transitions, weighing out of foodstuffs on peculiar tilting balances, long hours of bran washing in aid of those missing hormones, and the knowledge that introduction of carefully prepared dosages might prolong the physiological processes. At the same time, our brother chalones were suffering severe shock and making compensatory adjustments with the advent of newer methods of surgical removal of the thyroid. We were still in somewhat of a daze over what it was all about.

As the three-year anniversary drew nearer, gracefully the stage was being set for the much anticipated finale, the graduation ballet. With a quietly gay rhythm our hormonic two-steps, fox trots, and mazurkas had synchronized, and to the strains of the grand march the lancers of today emerged from the ballerinas of yesterday.

Purchasing Power

The medical and allied services received by a family or a community naturally bear some relation to the volume and kinds of sickness experienced. It cannot be stressed too much, however, that purchasing power is a far more decisive detriment of services received than health needs.

—From "Rural Health and Medical Care" by F. D. Mott and M. I. Roemer.

Hope is generally a wrong guide, though it is very good company by the way. *—Lord Halifax.*

The Auxiliaries

Auxiliary Units Aid Royal Edward Laurentian

In groups of ten or more, called Units, the Ladies' Auxiliary of the Royal Edward Laurentian Hospital, Montreal, volunteer special services to the two branches of the hospital—the Ste. Agathe and Montreal Divisions—and have taken over the welfare work associated with three children's wards at the Alexandra Hospital in Montreal. Successful money-raising projects have included a benefit performance of the Icecapades, sales of book matches, bridge parties, raffles, and sale of knitted and needle work. Proceeds have been devoted to the financing of a BCG clinic, a library and an occupational therapy program; paying the salary of a school teacher for patients at the Laurentian Division at Ste. Agathe; and redecorating rooms in the hospital. Each summer, too, children are sent to camp from the Outdoor Clinic of the Montreal Division.

Hotel Dieu Aid, Windsor, Begins 28th Year

Entering its 28th year, the Hotel Dieu Hospital Aid can look back upon a very successful 1948. The annual reports show total receipts as $2,047.61, with $1,195 of this amount being the total receipts from the gift shop. During the year, the Aid donated to the hospital a new chair for the x-ray waiting room and a new operating room table valued at $1,600.

* * * *

Morden, Man., Aids Hold Annual Meeting

Reports presented at the annual meeting revealed that 1948 was a successful year for the Morden Hospital Aid. The buying committee reported that 709 articles had been bought and 672 articles were sewn by the ladies. Combination radio and record players with records were placed in the nurses' home as a Christmas gift.

* * * *

Lending Library at Estevan, Sask.

For the convenience of patients in the hospital, the St. Joseph's Hospital Auxiliary has established a generous lending library. The Auxiliary is also sponsoring a newly-opened canteen at the hospital.

R. J. Weatherill Named St. Catharines Superintendent

Mr. R. J. Weatherill, business manager of the St. Catharines General Hospital since 1944, assumed his new duties as superintendent of that hospital upon the retirement of Miss Anne Wright. A graduate of the University of Manitoba in public administration and finance, he received wide experience while serving for 15 years as clerk-treasurer with the corporation of St. James, Winnipeg, and as administrative officer with the R.C.A.F. during World War II. Mr. Weatherill is a vice-president of the Ontario Hospital Association and a director of the Ontario Blue Cross Plan for Hospital Care. Another appointment to the administrative staff is that of Miss E. Bell Rogers as Director of nursing services. Miss Rogers was formerly registrar of the Alberta Association of Registered Nurses.

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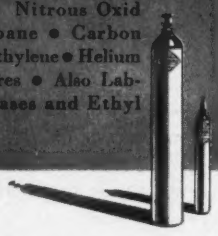

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B.C. Finds Difficulties In Unifying Personnel Practices

THERE would seem to be factors making it difficult to bring personnel practices and bargaining arrangements under the direction of the B.C.H.A. This was brought out at the annual convention this past autumn. The Executive had named a sub-committee of E. S. Withers, A. J. H. Swencisky, and George Masters, to bring in recommendations to the meeting for the guidance of the member hospitals. They reported as follows:

"Your Committee now beg to report they have given this subject consideration and they find that under existing conditions it is futile to have any committee of the B.C. Hospitals' Association for the purpose of discussing personnel practices with representatives of the Registered Nurses' Association. Such a practice cannot be pursued without infringement or interference contrary to the Provincial Labour Laws.

"Furthermore, it is impossible for the Executive or any committee thereof, to advise any hospital or group of hospitals on the question of personnel practices under existing conditions. Furthermore, contracts between graduate nurses and hospitals are falling due at many different dates in the year, a fact that is responsible for a substantial lack of uniformity in agreements.

"Your Committee, therefore, recommend that the question of nursing personnel practices as such be placed on the agenda for the forthcoming Convention, for the purpose of discussion as to whether it would be possible or practical for the B.C. Hospitals' Association to have a committee to serve as bargaining representatives for all hospitals who have written agreements with their nurses as a result of bargaining procedures.

"If the formation of such a bargaining committee meets, in principle, the favour of the Convention, it would then be necessary to ascertain from affiliated hospitals whether their governing boards would be willing to delegate their bargaining powers to such a Committee."

In the discussion Mr. Joseph McKenna, as chairman of the Constitution and By-laws Committee, noted that the Constitution did not permit the Association "to interfere with the policy of any hospital or hospitals". It was his opinion that the question of personnel practices is a matter of policy for the individual hospitals. However, vice-president Swencisky, also a member of the legal profession, pointed out that the Committee had taken cognizance of the restrictions of the Constitution and had made the activities of a possible bargaining committee contingent upon these bargaining powers delegated by the individual hospitals.

Mr. Percy Ward pointed out that some of the hospitals feel that they are in a weak position through lack of information and organization when dealing with groups which are well organized. Mr. Swencisky suggested that, as soon as any hospital has concluded a bargaining agreement, the details should be made known to the Association for distribution to the other hospitals. This would be a help in estimating trends. Mr. George Masters asserted that the Association should take some leadership in advising the hospitals and in having information available.

Mr. Harry Baxendale, of Duncan, reported that the Upper Island Regional had an agreement among all of the hospitals with respect to salary increases, et cetera, and that no hospital would take any action which was not agreeable to others.

Later, during the resolutions session, the following was approved:

"BE IT RESOLVED that this Association do recommend to all member hospitals that all agreements made with employees as the result of regotiations with any bargaining agency be made available to all member hospitals by a copy thereof being furnished to the Secretary so that any new features contained therein may be circulated by the Secretary to member hospitals."

It was pointed out that this motion was a recommendation only and not mandatory; also that it applied only to arrangements with bargaining agencies. A personal contract with an administrator, for instance, would be another matter.

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Health Care Plans

(Concluded from page 76)

anticipated that there will be set up a Blue Cross Health Service Association which will operate an insurance company providing uniform coverage for national groups. It is not clear, in the light of the A.M.A. action, whether or not the new corporation will also provide a measure of medical benefits to meet public demand.

This development will not likely affect the Canadian situation. The Blue Cross plans in this country are now working out a Canadian office to be the agent, as it were, of the Canadian plans for national enrolment and to handle other matters of joint concern.

* * * *

Miss Ruth Wilson, Chairman of N.B. Health Survey

Miss Ruth C. Wilson, executive director of the Maritime Hospital Service Association, has been appointed chairman of the health survey committe for the province of New Brunswick. Miss Wilson, Dr. Arthur VanWart, and Dr. Charles Gass form the voluntary advisory committee assisted by about ten subcommittees.

* * * *

Alberta Group Hospital Rates to Stand

Group subscribers to the Blue Cross Plan in Alberta will pay no higher premiums for their coverage even though hospital rates in that province have been boosted by 25 per cent. In order to meet the increased cost of hospital services, the Blue Cross executive has decided to issue no further contracts with individuals. Those individuals already belonging will pay a higher assessment, an increase from $1 to $1.25 for single persons and from $2 to $2.50 for families.

* * * *

"Blue Skies" for Blue Cross People

"Blue Skies", the latest addition to the family of publications of the Ontario Plan for Hospital Care, has been forwarded to all Plan groups and hospital trustees in Ontario. Carrying items of news and a sprinkling of interesting facts concerning the Plan, it is hoped that this semi-annual publication will be found informative, interesting, and helpful.

Hospital Nursing Services

(Continued from page 57)

bedside of the sick patient, be it at home or in the hospital.

Mechanical and Other Aids

Miss Janet Geister foresees other developments:

"Nursing service of 1998 will be used more economically, too, through the use of mechanical aids and improved construction. From her desk the supervisor will observe patients by television. She will talk to one, listen to the breathing of another through a two-way public address system. Bedsores will be prevented and gentle exercise will be provided by the oscillating bed. Nurses' backs will be saved by beds adjustable to various heights. Destroyable containers will replace bedpans. Water piped into wards and private rooms and strategically placed disposal facilities will cut down travel. Food prepared by electronic devices will provide 'hot things hot, cold things cold' on the instant. Jet injections in disposable units will eliminate the hypodermic syringe and needle and all their meticulous care."‡

Forecast

Looking into the crystal one sees a number of developments, although some of the images are not as clear as others:

1. The highly trained professional nurse of the future will be doing more specialized work and will not be doing tasks which could be done by others.

2. Many of the duties now being performed by graduate nurses and senior students will be assigned to well trained practical nurses and orderlies.

3. All those who nurse for hire will be licensed and adequate training for each category will probably be required by the state.

4. Hospitals will play a greater role in preventive medicine and in public health education. For this the nurse of the future will undoubtedly be given special training.

5. Nurse education will be undertaken primarily to train nurses, not primarily to obtain hospital nursing services. This transition may be aided by the obvious trend on the part of governments to pay more nearly what hospital care costs.

6. Although many—possibly most—schools may continue to be linked with individual hospitals, the trend will probably be for these schools to be financed independently of the hospital. This trend may well be a slow one.

7. More emphasis in the training of both administrators and supervisors in personnel relations. At the recent A.H.A. meeting, Miss Mildred Riese of Chicago, stated that, "One of the greatest lacks in the nurse-administrator today is her common lack of training in personnel relations."

8. The old authoritarian basis of discipline will probably be modified considerably in favour of the present day concept of teamwork, co-operation, and more satisfying and stimulating human relations.

9. In the future we should see more teamwork between hospitals respecting nurse education—more joint instruction in communities and more linking up of urban and rural hospitals. One hopes to see some of the undergraduate instruction taken in rural hospitals. This would have a dual effect: (a) get the students interested in rural hospital life, and (b) get rural girls interested in nursing.

10. There is now a difference of opinion respecting the merits of centralized teaching versus the present apprenticeship methods. We may well see a combination in the future. Girls may be registered in the hospital school of their choice but take theoretical training centrally and practical work in their own and other hospitals of varying size.

11. As nearly 90 per cent of our active treatment hospitals and practically all of the others do not have interns now, and can never hope to have them, many clinical duties (B.P. readings, intramuscular and intravenous injections, certain anaesthetics, et cetera) will be done by selected and especially trained graduate nurses. These "nurse clinical assistants" are now being recognized more and more and courses will be set up from time to time for their instruction.

12. Luxury nursing will be greatly reduced. If more provinces take over financial payments to hospitals, hospitals are more likely to employ adequate nursing staffs, thus minimizing the need for special nurses (as in military hospitals). If the situation gets too serious, the state

‡*The Hospital and the Nurse, Janet M. Geister, Reg.N., "The Modern Hospital", August, 1948.*

may even require the approval of a medical referee.

13. More and more of our instructors, administrators, and supervisors will probably have certificates and undergraduate degrees from university faculties of nursing.

14. Finally, with more early ambulation and early discharge, and with greater development under health insurance of public welfare and home nursing services, the hospital will become more concerned with follow-up care. In other words, a considerable degree of future hospital nursing will be done at home.

Gordon Earle Richards, M.D.

One of the foremost radiologists of this continent, Dr. Gordon E. Richards, died at the Toronto General Hospital on January 13th, in his 64th year. Professor of radiology at the University of Toronto and director of the department of radiology at the Toronto General Hospital, Dr. Richards was stricken a year ago with a blood condition found most frequently among persons exposed to radiation and which terminated in leukemia.

Beginning his career as a diagostic radiologist, Dr. Richards early became interested in radiotherapy and developed many special methods for the application of radium and x-ray in cancer treatment. He was a director of the Ontario Cancer Foundation and the Ontario Institute of Radio Therapy, an honorary member of the Royal Society of Medicine, a Fellow of the Royal College of Physicians and Surgeons, and a Fellow of the American College of Radiology. Two years ago, Queen's University conferred upon him the degree of Ll.D. (See Convocation address, *Canadian Hospital*, Sept. 1947, p. 25.)

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du Problème Hôpitalier

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partie intégrante de notre civilisation de plus en plus liée au paternalisme d'Etat. Avant longtemps les hôpitaux seront forcés d'agrandir tout en conservant leur quotient d'efficacité actuelle. Ce but ne peut être atteint sans préparation et un des premiers pas consiste dans la préparation du personnel requis.

Budget Planning

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three years: The proposed budget at this step would be classed as a preliminary budget.

General Policies

At this point, the general policies of the hospital should be decided with the budget committee. When this has been done each department head should be given the opportunity to bring his budget into line with the general policies and also to defend his proposed program. The result should be a departmental budget which both the administrator and the department head can support. If necessary, the general budget should be re-summarized and submitted to the board of trustees with recommendations by the administrator. If a satisfactory job has been done, the budget will meet with approval. In the event of any changes, it is always desirable to discuss the changes with the department heads involved.

One of the most profound benefits derived as a by-product of budgeting is the excellent insight we obtain into the problems and workings of our various departments. Too often lack of time prevents us from seeing any but the most pressing problems. Budgeting provides an objective picture of all the details of operation with which the administrator should be familiar.

The Good Earth

His toes curved in the black soil. It was marvellous to feel the good, cool earth beneath his feet again. Tenderly he bent down and crumbled a piece of sod between his fingers. A man was a fool to leave the land. He thought of the city with loathing. All it had brought him was unhappiness and sorrow, but that was all over. He was back to his first love, the earth. For a while he was silent in quiet contemplation; a prayer of Thanksgiving arose from his heart. Once more he was part of nature and not just a shadow in the city. A voice called, "Dinner's ready".

Slowly and reluctantly, he took his feet out of the flower pot.—*The Messenger.*

Clinical Laboratory

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ly established procedure. Reticulocyte counts and prothrombin time estimations aid tremendously in the diagnosis and management of haemorrhagic diseases. The study of bone marrow by sternal puncture and otherwise is a development of the period. The haematological study of nasal and bronchial smears is assuming importance.

Basal metabolism estimation, carried out quickly by modern simplified machines, has become the ordinary routine of the clinical laboratory, whereas, twenty-five years ago it was laborious and time-consuming with the methods then in vogue.

In *autopsy* work and in surgical pathological diagnosis, newer and more specific staining methods have been introduced. In autopsy diagnosis, the aid of bacteriology, serology, and pathologic chemistry, is now frequently sought in the elucidation of obscure deaths. In this regard, blood chemical and blood alcohol estimations often solve the case. Rapid diagnosis of surgical tissue by frozen section technique was exceptional twenty-five years ago; today it is routine in well-organized laboratories.

Laboratory Training

It has been possible in so short a presentation to touch upon only a few of the highlights. The modern clinical laboratory is now a highly technical department, calling for a technical staff of high attainments. It has been necessary over the past ten years to set up schools in the larger laboratories for their training. Twenty-five years ago, the requirements for technicians were not to be compared to those of today. The writer's department was among the first to organize a school for technicians and now gives an 18-month course of lectures and practical instruction to classes of ten candidates, all of whom must have at least senior matriculation standing, and many of whom have university degrees. There are about forty laboratories throughout Canada approved as training schools, yet there is a great shortage of qualified technicians. This is due to the great expansion in scope, type and quantity of the clinical laboratory service required by the hospitals of Canada, a demand which has kept pace with the phenomenal development of that service over the elapsed quarter century.